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Seminar Explores Cardiovascular Disease Research

The relationship between alcohol use and cardiovascular disease has posed something of a dilemma for those in the alcohol field, Charles Kaelber, M.D., Dr. P.H., said at a recent National Institute on Alcohol Abuse and Alcoholism (NIAAA) Epidemiology Seminar.

While the occurrence of some cardiovascular diseases—alcoholic cardiomyopathy and hypertension, for example—has been associated with heavy alcohol use, several studies have also shown that moderate consumers of alcohol appear to have a lower coronary heart disease rate than those who abstain, said Kaelber, who is chief of NIAAA's Laboratory of Epidemiology and Population Studies. "We may have to live with a certain amount of ambiguity, because there's no reason to expect alcohol to have a single effect on the heart and blood vessels," Kaelber said.

According to Kaelber, alcohol has not one but multiple sites of action within the cardiovascular system, and thus may affect different cells in different ways. Abundant evidence suggests that alcohol acts directly on the heart muscle as well as on the coronary arteries and on the central and peripheral nervous systems which influence cardiovascular function, he said. Evidence also suggests that the acute or short-term effects of drinking may differ from the chronic effects of long-term drinking in which biochemical changes lead to structural damage.

In addition, he said, alcohol's effects are dose dependent, with higher doses possibly exerting effects quite different from those of lower doses. Finally, alcohol's effect on the heart may vary depending on other factors that cause individuals to react differently.

In discussing cardiovascular diseases associated with the use of alcohol, Kaelber said that alcoholic cardiomyopathy or enlargement of the heart was recognized as a distinct entity and included in the international classification of diseases in 1979. However, it had first been identified more than 100 years earlier among beer drinkers of Munich, Germany. Initially dubbed the "Munich beer heart," it gradually became clear that the condition was specific neither to Munich nor to beer drinking.

Cardiomyopathies in the early stages can be detected by EKG changes, Kaelber said. As the heart chambers and muscle mass slowly and insidiously enlarge, the heart's effectiveness as a pump decreases. Eventually, death occurs commonly from congestive heart failure.

The diagnosis is made by exclusion of other causes of cardiomyopathy. One looks for other possible causes of enlargement, and then considers alcohol if there is a history of heavy drinking. A persistent notion since the turn of the century has been that a specific substance or toxin in beer or alcohol might be responsible although one has never been found, Kaelber said. Also, in the early 1920s, a thiamine deficiency was suspected as a cause of heart enlargement, since thiamine administration helped some patients. In the 1950s and 1960s it became clear that thiamine deficient cardiomyopathy and alcoholic cardiomyopathy were two distinct entities. Alcoholic cardiomyopathy is not common even among heavy drinkers, Kaelber said, and those who do develop it typically do not develop liver cirrhosis, and vice versa.

The relationship between alcohol and hypertension surfaced in epidemiologic cardiocascular disease studies of the 1950s, Kaelber said.

One of these studies involved men working for the Chicago Western Electric Company. In 1957-58, these men were given a free medical exam after which their health status was followed for several years. The incidence of hypertension increased among the men as their average daily alcohol intake went up, Kaelber said. Twenty percent of those who abstained were defined as hypertensive, while 26.9 percent of those who drank two to three drinks daily were hypertensive, and 47.4 percent of those who had six or more drinks daily were hypertensive.

What remains unclear from these early studies is whether high blood pressure precedes heavier alcohol use or vice versa. It is also possible that no causal relationship exists—that other factors such as stress, for example, may contribute to both attributes. Nonetheless, the recommendation of most clinicians at this time is for hypertensive persons to moderate alcohol consumption for a variety of reasons, including, for example, to control weight, Kaelber said.

Atherosclerosis, or the clogging of the arteries with cholesterol and other fat deposits, also has been linked to alcohol consumption, although study findings are not all consistent.

In discussing the possible protective effects of alcohol use, Kaelber said that in the late 1950s it was observed that moderate consumers of alcohol appeared to have a lower coronary heart disease mortality rate than those who abstained. The Honolulu Heart Study, reported in 1980, confirmed these findings. Hawaiians of Japanese descent who consumed at least 40 ounces of alcohol monthly had the lowest coronary heart disease rate of those studied. However, the risk for other complications such as liver cirrhosis and cancer increased with increasing alcohol consumption, Kaelber said.

Other studies also have confirmed the association between a low death rate for coronary heart disease and moderate drinking, he said. The effect appears to be related to alcohol's elevation of HDL (high density lipoprotein) cholesterol, the "good" cholesterol associated with low levels of coronary heart disease. LDL (low density lipoprotein) cholesterol, normally present in greater amounts in the body than HDL cholesterol, has been associated with higher mortality.

Because this is such an important public health issue with various implications for prevention, further research studies are needed to help clarify the effects of alcohol on the cardiovascular system, Kaelber concluded.

For further information, contact Charles T. Kaelber, M.D., Dr. P.H., Laboratory of Epidemiology and Population Studies, NIAAA, Room 16C16, 5600 Fishers Ln., Rockville, MD 20857.

—*Nancy Johnson*

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • PUBLIC HEALTH SERVICE • ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

HE 20. 8312:

Arizona Group Studies Drinking Habits of Elderly

A recent 4-year NIAAA-funded study of drinking habits among elderly persons in rural Arizona contradicts the popular belief that alcohol consumption in this group increases in response to the physical and social effects of aging. According to principal investigator, Victor A. Christopherson, Ed.D., "The elderly appear to diminish or discontinue drinking rather than turn to alcohol as a means of coping with the frustration of senescence."

Christopherson and his colleagues at the University of Arizona's Office of Human Development and Family Research investigated the alcohol use patterns of 429 men and women, 65 to 111 years old. The largest percentage of subjects, 39 percent, fell into the 65 to 69 age group; 25.1 percent of those interviewed were 70 to 74, 19.1 percent were 75 to 79, 10.9 percent were 80 to 84, and 5.9 percent were 85 years old or older. According to Christopherson, the study group — who answered questions about their past and present drinking patterns, their health, their reasons for drinking, and their attitudes toward alcoholism — was representative of the rural elderly population in Arizona in terms of ethnicity (81 percent were white), marital status (55.9 percent were married, 36.2 percent were widowed), and religion (59.5 percent were Protestant).

The researchers concluded that "aging and drinking were not directly nor significantly correlated for the rural elderly in Arizona." In fact, the researchers found a trend toward decreasing amounts of drinking with increasing age. The researchers wrote, "The principal decrease appears to take place concurrent with or soon after retirement. The drinking patterns became more stable as individuals moved beyond the retirement age. This finding reflects a second trend, that is, the tendency for alcohol use patterns to persist."

Christopherson's findings failed to confirm the popularly held idea that elderly people turn to alcohol to assuage feelings of loneliness brought on by the increasingly frequent deaths of spouses and friends. "The widowed group had the highest rate of nondrinking (68 percent) and the lowest rate of heavy drinking (8 percent)," they wrote. As is true of the general population, the lowest rates of abstention and the highest percentage of heavy drinkers was found among those people who had been divorced or separated.

Religion was found to relate to elderly persons' drinking habits much as it does in the case of the general population. Mormons had the highest rate of abstention, while the heaviest drinking and lowest abstention rates were found among those who claimed no religious affiliation. Catholics and Protestants "fell between the two extremes," they wrote.

Also, according to Christopherson and his colleagues, "While there were elderly persons who may suffer the consequences of alcohol abuse and/or alcoholism, the majority of the elderly have adapted their drinking patterns to their life situation." The researchers pointed to a drop in, and subsequent leveling off of, consumption rates among most people as they approached retirement age as evidence that "as events and circumstances force changes," the elderly "adjust their behavior accordingly."

However, the researchers pointed out that a certain amount of ignorance about alcoholism exists among the rural elderly population. Subjects responded "don't know" to many questions asked about their perceptions of the seriousness of alcoholism in their community. And, as in the general population, those elderly persons classified as "heavy drinkers" tended to agree least with the statement that "anyone who drinks could become an alcoholic." The research team concluded that "the findings in this study point the need for a major public education effort for all age groups as regards alcohol usage and addiction."

For more information, contact Victor A. Christopherson, Ed.D., Office of Human Development and Family Research, University of Arizona, 210 Home Economics Bldg., Tucson, AZ 85721.

—Jill Vejnoska

Training Packages Available

The National Center for Alcohol Education (NCAE) of the National Institute on Alcohol Abuse and Alcoholism has developed a series of training packages available free of charge to trainers, State alcoholism authorities, and groups and organizations that run training programs. The training packages have been used in a variety of settings, including large hospitals, colleges and universities, continuing education departments, and workshops put on by State authorities and other groups.

Training packages include *Counseling Alcoholic Clients, Initial Visit, Management Skills, Planning Alcoholism Services, Programming Community Resources, Services for Alcoholic Women, Training Alcoholism Trainers, Using Volunteers in Your Agency, You, Youth and Prevention,* and *Group Skills for Alcoholism Counselors.*

According to NCAE director Maureen Carroll, the training packages have been enthusiastically received in the field and used in a wide variety of settings. For example, the Volunteer Resource Development Program in Albuquerque (NM) used the Volunteers package in 12 workshops to train 181 people. In three continuing education courses, Fairmont Community College in Fairmont (WV) used staff training packages in conjunction with the West Virginia Department of Health, the Fairmont Council of Churches, and the Marion County Council of Social Agencies. Continuing education courses at colleges and universities throughout the country have also made use of the training packages.

The training packages are available to qualified individuals and groups and further information and order forms can be obtained from the National Center for Alcohol Education, 5530 Wisconsin Ave., Suite 1600, Chevy Chase, MD 20815.

Program Assists Family Members

The Maplegrove Alcoholism Treatment Center at Henry Ford Hospital in Detroit (MI) has begun a program to assist family members of recovering alcoholic patients. So far, more than 40 families have taken part in the outpatient family education and therapy program, involving 35 hours of lectures, discussions, group therapy sessions, Al-Anon meetings, and discussion of family autobiographies. The program lasts for 28 days, and aftercare sessions are available for both family members and patients.

For further information, contact Jane Eckels, Public Relations Office, Henry Ford Hospital, 2799 West Grand Blvd., Detroit, MI 48202.

meetings

Feb. 15 - 19. Minneapolis, MN. Basic Workshop on Chemical Dependency and the Family. Contact JoAnne Terry, Johnson Institute, 10700 Olson Memorial Hwy., Minneapolis, MN 55441.

Feb. 18 - 19. El Paso, TX. Sixth Annual Conference on Alcoholism. Contact Rita Chrane, Office of Continuing Medical Education, Texas Technical University Health Sciences Center, Lubbock, TX 79430.

Feb. 18. St. Louis, MO. Symposium on Alcohol and Drug Abuse. Contact George Hamlin, the Edgewood Program, St. John's Mercy Medical Center, 615 South New Ballas Rd., St. Louis, MO, 63141.

Feb. 28 - Mar. 5. Minneapolis, MN. Workshop on Chemical Dependency and Adolescents. Contact Janet Winsand, Johnson Institute, 10700 Olson Memorial Hwy., Minneapolis, MN 55441.

Mar. 5. San Francisco, CA. Special Issues in Addiction Counseling. Write to Private Treatment Providers Alcohol and Drug Association, P.O. Box 754, Lafayette, CA 94549.

Mar. 6. Cambridge, MA. Fifth Annual Alcoholism Symposium: The Treatment of Special Populations. Contact the Division of Continuing Education, The Cambridge Hospital, Department of Psychiatry, 1493 Cambridge St., Cambridge, MA 02139.

Mar. 21 - 23. Atlantic City, NJ. ACCEPT 82: A conference on developing alcohol/drug education and intervention strategies in school systems. Contact D. Jensen, Conference Coordinator, NCA of Ocean County Inc., 528 River Ave., Lakewood, NJ 08701.

Mar. 28 - Apr. 2. Park City, UT. "Health and Addiction Seminar." Contact Dan Barmettler, Institute for Integral Development, P.O. Box 2172, Colorado Springs, CO 80901.

Mar. 31-Apr. 1. Cincinnati, OH. Third Regional Conference on Substance Abuse. Contact Ann Blakenhorn, Central Community Health Board, 532 Maxwell Ave., Cincinnati, OH 45219.

May 6 - 7. Eagleville, PA. Fifteenth Annual Eagleville Conference. Contact Patricia Moretti, Eagleville Hospital and Rehabilitation Center, P.O. Box 45, Eagleville, PA 19408.

June 7-10. Kansas City, KS. Third Annual National Conference on Employee Assistance Programming. Contact the EAP Conference Center, Bethany Medical Center, 51 North 12th St., Kansas City, KS 66102.

July 25 - 31. Edinburgh, Scotland. Twentieth International Congress of Applied Psychology (includes a symposium on alcoholism). Contact Dr. H.G. Tittmarr, School of Psychology, Ulster Polytechnic, Newtownabbey, BT37 N. Ireland, U.K.

NIAAA Information and Feature Service (IFS) is a service of the National Institute on Alcohol Abuse and Alcoholism. The opinions expressed in the articles do not necessarily reflect the view of NIAAA.

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Editor: John Small
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recent publications

Recent Topics in Alcohol Studies; abstracted overviews of recent international scientific and technical literature in more than 60 subject areas, as culled from the Alcohol Information Retrieval System. *Retrospective Bibliographies;* a bibliography, updated yearly, containing comprehensive coverage of the retrospective literature on frequently requested alcohol topics. Includes information on obtaining cited documents. For information on price and availability of both bibliographies, contact Information Services, Dept. P, Center of Alcohol Studies, Rutgers University, P.O. Box 969, Piscataway, NJ 08854.

Alcohol Problems and Alcoholism, by James E. Royce; The Free Press/MacMillan Publishing Co., Inc., 2000 Brown St., Riverside, NJ 08370; 1981; 384 pp.; $16.95. A complete overview of the alcoholism field, covering all aspects of the scope, nature, causes, treatment, and prevention of alcohol misuse. Contains 752 references.

Drinking To Your Health, by John A. Ewing, M.D.; Reston Publishing Co. Inc., 11480 Sunset Hills Rd., Reston, VA 22090; 1981; 225 pp.; $13.95 (cloth), $8.50 (paper). The author, director of the Center for Alcohol Studies and Professor of Psychiatry at the University of North Carolina's School of Medicine, calls this "a straightforward, no-nonsense book for the average individual who wants to know all that is necessary without detailed documentation or scientific references." A final section of the book contains more advanced information. Also includes a "drinking diary" for those persons who wish to monitor their drinking habits.

Drinking: Alcohol in American Society: Issues and Current Research, edited by John A. Ewing, M.D., and Beatrice A. Rouse; available from Publication Division, National Council on Alcoholism, Inc., 733 Third Ave., New York, NY 10017; 1981; 456 pp.; hardcover $23.95 plus $1 handling; softcover $11.95 plus $1 postage and handling. Works by 19 different authors are integrated into this one volume, covering all aspects of drinking — biological, psychological, sociological, and legislative. Among topics discussed are the history of alcoholic beverages, highway safety problems, alcohol use among teenagers, as well as the medical, social, and psychiatric aspects of drinking.

Confidentiality Issues in Workplace Settings; available from the Industrial Social Welfare Center, 622 West 113th St., New York, NY 10025; 1981; $2.50. A working paper that considers the rights of workers to privacy and confidentiality in their dealings with employee assistance programs. The paper also contains sections on policy issues and guidelines, client records, and matters of consent.

The Bibliography of North American Indian Mental Health, compiled by Dianne R. Kelso and Carolyn L. Attneave; Greenwood Press, 88 Post Road West, Westport, CT 06881; 404 pp.; $39.95. Contains entries pertaining to psychological problems unique to Indians, as well as more "conventional" problems; author indexes, glossary of technical terms, and a tribe and cultural area list are also included.

Preventing Alcoholism: Primary Prevention; the Christopher D. Smithers Foundation, P.O. Box 67, Mill Neck, NY 11765; 1981; 90 pp.; $2.50 plus $.60 shipping. A workbook on primary prevention that can be used as a guide for establishing prevention programs in industry and in schools or for research.

Fact Sheets Focus on Alcohol Topics

The National Clearinghouse for Alcohol Information publishes a series of *Fact Sheets.*

The 1- to 2-page *Fact Sheets* focus on a variety of topics, including *ABC Laws* (order no. MS 202), *ABC Laws: Prohibited Hours of Sale* (MS 203), *Estimated Patterns of American Adult Drinking Practices* (MS 207), *State Dedicated Alcohol Taxes* (RPO 152), *Facts on Alcohol Use Important to Industry* (RPO 100), *Decriminalization of Public Intoxication* (MS 204), *It's Dangerous to Mix Alcohol and Drugs* (ENCAS 7601), *Apparent Consumption of Alcoholic Beverages* (MS 236), *Credentialing of Alcoholism Counselors* (MS 231), *Selected Statistics on Alcohol and Alcoholism* (MS 245), and *Alcoholic Beverages Calorie Chart* (MS 241).

To order a *Fact Sheet* free of charge, please specify the title and order number. Write to the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852.

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NRC Prevention Report Analyzes Alternative Policies

The National Research Council (NRC) has issued a 463-page report, *Alcohol and Public Policy: Beyond the Shadow of Prohibition,* which is the result of an NIAAA-sponsored panel study of alternative policies affecting the prevention of alcohol abuse and alcoholism.

The panel found that such controls as excise taxes, drinking age limits, and other public policy instruments can influence drinking behavior and its outcomes.

The 13-member study panel, set up by the NRC's Committee on Substance Abuse and Habitual Behavior, was chaired by Mark Moore of the John F. Kennedy School of Government, Harvard University. The National Research Council is an arm of the National Academy of Science, the National Academy of Engineering, and the Institute of Medicine.

A widespread belief that America's Prohibition experience "demonstrated once and for all the futility of attempts to legislate morality" has clouded discussion of research on alcohol control policies, but the possibilities of reducing alcohol abuse problems by preventive measures "are modest but real," the panel observed.

"The law is a clumsy and expensive instrument to wield in shaping private drinking practices," the panel said. "But in one area we think it feasible and desirable to do so: the regulation of drunken driving."

Studies of auto-accident statistics from several States where the minimum alcohol-purchase age was lowered yielded "consistent evidence that the age reduction resulted in an increase in the ratio of auto crashes and fatalities involving youthful drivers," according to the panel.

Prevention programs that combine advertising and information campaigns with personal instruction provided through schools, volunteer associations, or health maintenance organizations have shown sufficient promise to warrant further experimentation, the panel held.

Taxation appears to affect the consumption level of heavy drinkers as well as those who drink less, the report says, but further research is required to determine more closely the effect of price increases on the demand for different types of alcoholic beverages.

Price increases also can be linked to reduction in the incidence of alcohol-related problems, according to the panel. Examination of liquor tax increases that occurred in 30 States from 1961 to 1975 indicate that "even relatively small changes in prices may influence not only the quantity of consumption but also the most serious health effects as well," including highway fatalities and cirrhosis deaths.

Drinking practices are shaped by a variety of factors, including psychological needs, religious traditions, and government restrictions on the availability of alcohol. "Alcohol policy would benefit from the identification of those factors that are powerful but can be efficiently influenced by government." That, the panel acknowledged, is a "difficult combination."

Seven commissioned papers are appended to the panel report; the papers were used by the panel in its deliberations. The panel report contains six chapters that cover simplifying conceptions of alcohol problems and policies, the nature of alcohol problems, perspectives on current alcohol policies, regulating the supply of alcoholic beverages, shaping drinking practices directly, and reducing environmental risk.

The report is available for $15 from National Academy Press, 2101 Constitution Ave. NW., Washington, DC 20418.

Conference Addresses Alcohol Issues

An eastern regional conference of the Alcohol and Drug Problems Association of North America (ADPA) brought together more than 200 health care professionals, planners, and administrators recently in Washington (DC).

The 4-day conference included plenary sessions and workshops on accreditation, employee assistance programs, third-party coverage, Federal and State legislation and funding, women's issues, minority issues, and nurses' issues.

In her keynote address, LeClair Bissell, M.D., then president of Edgehill-Newport, a freestanding alcoholism treatment facility in Newport (RI), called the 1980s a "decade of decision" and urged those in the alcohol field to work even harder to ensure continued progress. She called for an ongoing Federal presence in the field and said that a great deal had been accomplished "in a short span of only 10 years." Also, she said, those in the field must continue dialogue on third-party coverage for alcoholism treatment, which Bissell said, "can give programs some real permanence and move alcoholism and other chemical dependencies into the mainstream of health care."

In a plenary address, Gary Graham, M.D., medical director for the Kemper Insurance group in Long Grove (IL), discussed "The Future of Third Party Funding of Alcohol and Drug Abuse Services." Graham urged those in the alcohol field to assist the insurance industry by supplying evaluation data on the effects of extending third party payments for alcoholism treatment. Graham said he was optimistic about the alcohol field and saw the 1980s as an "age of refinement" for alcohol programs. Other plenary addresses focused on insuring the continuation of sound alcohol and drug abuse services and the future of the alcohol and drug abuse field.

ADPA has also issued a call for papers for its annual meeting to be held August 29 – September 1 in Washington (DC). The abstracts, which are due March 15, should focus on new applied research, cost-cutting, effective treatment modalities, etc.

For further information on the conference, contact Roger Stevenson, Executive Director, Alcohol and Drug Problems Association of North America, 1101 15th Street NW., Suite 204, Washington, DC 20005.

—John Small

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HE 20. 8312:

Researchers Propose Relapse Models

If you had heart disease, your family probably would know the warning signs and what to do in case of a heart attack. The same would be true if your were diabetic or epileptic. But, according to Terence Gorski and Merlene Miller of Alcoholism Systems Associates in Hazel Crest (IL), no comparable information on relapse prevention exists for alcoholics and their families.

In their book *Counseling for Relapse Prevention*, the three urge that patients be taught — while still in treatment — how to recognize the warning signs of recidivism and to develop and use relapse prevention plans. "Relapse begins in behavior that reactivates patterns of denial, isolation, elevated stress, and impaired judgment" they say. "Relapse is a process and a process can be changed or interrupted at any time."

In a presentation at the 1981 National Council on Alcoholism (NCA) Forum in New Orleans, Gorski said that his studies over the past 10 years have shown that "as many as 30 percent of total treatment beds are filled by recidivists, people who have been treated before." In 1973, Gorski said, he completed interviews with 118 alcoholic patients at Grant Hospital in Chicago (IL). All of the patients had been treated before but had subsequently returned to treatment when their drinking and behavior got "out of control in spite of initial commitments to remain sober." Gorski concluded that recidivists share common symptoms and hypothesized that, if they and their families could be taught to recognize these symptoms, they might be able to recognize warnings signs and take action to forestall possible relapses.

In the years following Gorski's initial study, the three continued to examine the relapse process, until, ultimately, they identified seven "relapse models," or categorical explanations for alcoholic recidivism. Gorski explained at the NCA conference, "The commonly held belief that most patients who relapse do so because they are not motivated to recover simply did not prove true under clinical observations. Lack of motivation was found to be only one of seven possible models that could describe the relapse dynamic in those patients we studied." The seven relapse models identified by Gorski and his colleagues are:

- Motivational Model—Patient initiates treatment because of outside coercion rather than a personal desire for recovery, and never attains the inner motivation to really pursue sobriety
- Progressive Relapse Model—Patient experiences progressive (and predictable) warning signs of relapse, but because he or she has never been taught to recognize or interrupt these symptoms, they continue unheeded until the patient loses control
- Attitudinally Based Model—Patient initiates treatment with sobriety as a priority, but the illusion of rapid recovery combined with outside social pressures change his or her attitude toward treatment, thus undermining the patient's resolve
- Neurologically Based Model—Patient experiences severe post-acute withdrawal (PAW) or neuropsychological problems that result in thought impairment, emotional instability, and memory disorders. These grow in severity until the patient perceives alcohol as the only viable means of regaining normal functioning
- Multiple Diagnosis Model—Patient suffers from a coexisting personality or psychiatric disorder that interferes with recovery
- Physical Illness Model—Patient suffers from a coexisting physical illness that produces chronic pain or discomfort. Since most alcoholism treatment programs do not permit pain killers and sleeping medications without teaching other methods of pain control (i.e., biofeedback), the patient becomes overstressed from the pain, and relapses
- Treatment Inadequacy Model—Patient seeks treatment in a facility that does not diagnose or effectively treat the broad spectrum of alcohol-related problems. Since the patient is not provided with the minimal baseline treatment required for recovery, he or she relapses soon after leaving the facility.

These relapse models account for 99 percent of all recidivist patients, Gorski said. Despite the possibility that recidivist alcoholics can fit into any or more than one model, Gorski and Miller say that the same relapse prevention planning process can be used by all alcoholics. In his presentation at the NCA conference, Gorski reiterated the importance of developing individualized relapse prevention programs — but including the same basic steps — for alcoholic patients. "The bottom line is that a complete treatment program teaches the person how to live again," he said. "This system is a complete process, and a teachable method that works."

In their book, the authors discuss 37 symptoms most commonly exhibited by alcoholics who are relapsing into drinking problems.

Miller reported that she and her colleagues developed a nine-step prevention planning method to be used by patients who are being treated for alcoholism. The first step—which encompasses all the other steps in the process—is education. The authors wrote that patients "should review the 37 warning symptoms of relapse and learn to describe examples of the general process and specific symptoms." Subsequent to education is "personalization," Miller says. "We ask patients to identify those symptoms that are most likely to happen to them, specifically." Patients are then encouraged to develop their own plans of action, Miller says, "to decide 'what I should do if this happens to me.' " The family of the alcoholic plays a major role in any relapse prevention plan and, consequently, is included in some of the training sessions. "The family is brought in and taught what to do in the case of relapse—how to recognize it and how to interrupt it," Miller explains. If relapse symptoms should appear, one patient's plan might call for increasing the number of AA meetings he or she attends, while another's might call for move involvement with and greater attentiveness on the part of the family. "The most important thing is that there is an individual plan for each patient," Miller concludes.

For more information on relapse and relapse prevention planning, contact Merlene Miller or Terence T. Gorski at Alcoholism Systems Associates, Inc. (ASA), P.O. Box 184, Hazel Crest, IL 60424.

—Jill Vejnoska

Women at Increased Risk For Alcoholic Liver Disease

Women tend to develop alcoholic liver disease more readily than men and should drink considerably less than men to avoid development of such diseases say J.B. Saunders, M.B., and associates of King's College Hospital and Medical School in London, England, in a recent review of published studies appearing in the *British Medical Journal* (Vol. 282; April 4, 1981; pp. 1140-1143).

Twenty years ago, alcoholic cirrhosis was a disease primarily affecting middle-aged and elderly men, the investigators say. Men outnumbered women by a nearly 5 to 1 ratio. In the past 10 years, however, the ratio has become 2 to 1. Four times as many women with alcoholic cirrhosis were hospitalized in 1977 as in 1970.

"The increased frequency of alcoholic liver disease among women is not surprising," the authors say, in light of increased alcohol consumption among women. "But the extent of the increase over the past 10 years is far greater than one would predict from the change in frequency of other alcohol-related problems." Noting that "5 to 10 times as many men as women are problem drinkers, in contrast to the 2 to 1 ratio for those with liver disease," the authors suggest that "women may develop alcohol-induced liver damage when consuming smaller quantities of alcohol than men."

The investigators found that most past studies supported this observation. One early Boston study showed liver disease occurred in 14 of 20 female alcoholics (70 percent) studied compared with 41.2 percent of male alcoholics studied. A more recent study found that the most severe form of alcoholic hepatitis occurred in 11.5 percent of the women but in only 3.3 percent of the men studied.

The studies suggest that women tend to drink less and for a shorter period of time than men before liver disease occurs.

Why a woman can drink only about half as much as a man and still develop cirrhosis remains a puzzle. The investigators speculate that differences in body composition may be partially responsible. Women have relatively more fatty tissue than men (33 percent as opposed to 21 percent), which, because of its poor blood supply, takes up alcohol less readily. "Hence, even if dose is adjusted for body weight, this results in higher blood concentrations in women than men and may be expected to cause more liver damage," they say.

They also note that women are more likely than men to develop autoimmune disorders such as rheumatoid arthritis in which the body is attacked by its own natural defenses against infection. "Because of their greater propensity for autoimmune reactions, female drinkers may be more likely to develop alcoholic hepatitis and by so doing progress to cirrhosis more rapidly than men," they say.

The researchers suggest that more treatment programs be designed for women. Family therapy may be particularly valuable, as many women may have husbands who are heavy drinkers, they say. Assertiveness training and treatment of coexisting depression, particularly common in women, also may be beneficial.

Women also must be included in screening programs that, until now, have focused on men, they say. Doctors must be more alert to possible liver damage in women with nonspecific abdominal symptoms and should make greater use of screening tests designed to detect high alcohol intake. Finally, the researchers say, educational programs are needed to increase awareness among women of hazardous drinking levels.

For more information, contact J.B. Saunders, M.B., M.R.C.P., King's College Hospital and Medical School, London, England, SE5 9RS.

—Nancy Johnson

NIAAA Clearinghouse Holds User Workshop

Representatives from 14 States participated in the second National Institute on Alcohol Abuse and Alcoholism (NIAAA) Clearinghouse User Workshop held last December. The main purpose of the 2-day workshop was to examine the changing information needs of States within the context of the products and services of the Clearinghouse.

The 14 participants represented a geographic cross section of States and included policy makers, program specialists, and prevention specialists.

In workshop sessions, participants were asked to select the Clearinghouse products and services that were most valuable to them. Other sessions were devoted to a discussion of how State agencies use various Clearinghouse products and services. Rick Cady, of the Oregon Office of Programs for Alcohol and Drug Problems, said that with decreasing funds to purchase materials many State offices will rely more heavily on photocopying brochures and pamphlets. Participants also were asked to develop ideas that would lead to a closer working relationship between the Clearinghouse and State agencies.

Karol Kumpfer, Assistant Director of the Utah Division of Alcoholism and Drugs, noted that State agencies conduct a great deal of analysis in preparing their grant applications. "Some of these applications," Kumpfer said, "provide excellent summaries of research, analyses of literature, and analyses of trends. I am sure other States would find this information useful. The problem is that we have no effective way to disseminate this information."

The participants suggested that the Clearinghouse establish a network of State contacts to serve as an ongoing liaison between each State agency and the Clearinghouse. State Directors would be consulted in the establishment of this network and would be invited to appoint one individual to serve the role of Clearinghouse liaison.

The Clearinghouse liaisons would be asked to collect and forward to the Clearinghouse all pertinent materials produced by the State agency that would be of use or interest to a broader audience. The Clearinghouse would then analyze the material and determine the most effective channels of dissemination.

In addition, as Clearinghouse products and services are developed or redesigned, the network of State liaisons would be contacted and asked to comment on how well the proposed product or service meets the needs of those working in alcohol programs.

The user workshop for State agencies was the second such workshop sponsored by the Clearinghouse during the past year.

—John McGrath

Hospital Alcohol Program Utilizes Seven Components

The alcohol program of the Franklin County (MA) Public Hospital is a beacon of hope for problem drinkers and their families in one rural Massachusetts county, providing a comprehensive continuum of services ranging from a detoxification center to halfway houses to early intervention programs.

Know as the Beacon Programs, the seven-component treatment and counseling operation is centered in Greenfield. The Beacon Clinic treats outpatients and their families, while the Beacon Houses for men and women treat persons with alcohol problems on an inpatient residential basis. In addition, medical treatment for alcohol withdrawal is available through the Beacon Detoxification Program. The Beacon Early Intervention Program and the Beacon Education Program identify persons who already have problems with alcohol or who may have potential problems and encourage their participation in the Beacon Programs. Two other facilities provide non-alcohol-specific services. Services at some of the components—such as the Beacon Clinic—are covered by health insurance; however, program officials say that "no one is refused help because of financial reasons."

According to Ruth Yanka, alcoholism service manager for the hospital, the 17,000 people who live in Greenfield are by no means the only group to whom the hospital directs its services. "The real challenge to our visibility," she says, "is trying to reach the other three-quarters of the population of Franklin County—the people who live in rural communities." A variety of organizations and other helping resources in Franklin County are involved in the program, expending effort to assure that persons with alcohol problems are identified, routed to, and encouraged to stay in the Beacon Programs. A unique combination of outreach and referral activities—all designed to involve whole communities—supports this process.

Yanka says that a significant portion of the Beacon Programs' outreach activities are channeled through its education and prevention components, which "remain visible" by placing articles about alcoholism and the Beacon Programs in local newspapers, by scheduling individuals to speak to Rotary Clubs and other service organizations, and by encouraging community members to play active roles in reducing alcohol problems in Franklin County. The Beacon Education Program informs community social service agencies, school systems, civic groups, and the general population about alcohol problems, and encourages them to implement prevention and referral programs. Also, the education program provides up to 30 hours of alcohol education.

The Beacon Early Intervention Program provides more specific community involvement to increase the probability of identifying potential problem drinkers. The driver alcohol education program—which consists of an intake evaluation session, eight education sessions, a reevaluation interview, and aftercare—relies primarily on court referral of persons who have been arrested for driving while intoxicated (DWI). Other facets of the early intervention component are a juvenile court referral program, a school referral program, and an "other alcohol-related offenses" court-referral program.

Community support is also part of the treatment process at the Beacon Houses for men and women in preparing individuals with drinking problems for their eventual return to the community. "We help them become stable within their smaller community first," explains Yanka. Residents of the single family dwellings eat in a homelike atmosphere, pursue recreational activities, receive vocational counseling, and participate in their own governmental unit as well as in Alcoholics Anonymous (AA) meetings and other discussion groups. The groups center on "the problems these people will have when they go back to their community," Yanka says. The Beacon Houses are termed "transitional group living residences" because, says one program official, they are directed at people "who have demonstrated a willingness to overcome their drinking problems, have a potential for employment, training, or education, and can assume independent status within 12 months after becoming a resident of the House."

Finally, the Beacon Programs reflect the benefits that come from having staff members who are willing to work with each other and who recognize the importance of a comprehensive alcoholism treatment plan to this rural region. Says Yanka, "These umbrella houses provide access to a helping network. It doesn't matter at what point you enter the system—you can still obtain any or all of its services." For example, a person brought to the Beacon detoxification program for supervised alcohol withdrawal would eventually be evaluated and referred elsewhere in the Beacon system for post-detoxification treatment. According to Yanka, detoxification program staff might refer the individual to one of the Beacon residential houses or to the Beacon Clinic outpatient component. Whatever the referral, she says that the treatment is likely to be successful because "staff in all the different components work together to assure that people with problems don't get 'lost in the cracks.'" This close coordination of effort also allows for post-treatment evaluation and followup.

The Beacon Programs are funded through a joint effort of the Massachusetts State Division of Alcoholism and the Franklin County Public Hospital.

For more information on the Beacon Programs, contact Ruth Yanka, Franklin County Public Hospital, 57 Beacon St., Greenfield, MA 01301.

—Jill Vejnoska

Task Force Formed In Pennsylvania

Pennsylvania Gov. Richard Thornburgh has formed a statewide "Task Force on Driving Under the Influence of Alcohol and Other Controlled Substances" to examine the effectiveness of current enforcement systems and to recommend improvements. The Task Force includes local criminal justice officials—district justices, judges of the Court of Common Pleas, district attorneys, and police officers—as well as representatives of local alcohol rehabilitation programs, the insurance industry, the medical profession, and the Pennsylvania General Assembly.

The Departments of Transportation and Health in Pennsylvania are making alcohol traffic safety a priority. An Alcohol Safety Advisory Committee, created in January 1981, has already identified measures that could help reduce the number of alcohol-related accidents within the State and the Task Force will further examine these recommendations.

For further information, contact Joyce Tomana, Department of Transportation Press Office, Room 1210, Commonwealth of Pennsylvania, Harrisburg, PA 17120.

—John Small

Workshop Addresses Prevention in Schools

A recent workshop on the Prevention of Adolescent Health Problems and the Schools brought together 15 educators and health professionals to focus attention on the need for integrating health promotion into school policies and programs. The workshop was sponsored by the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) and the Centers for Disease Control (CDC), which were seeking advice on an appropriate Federal role in maintaining the momentum of prevention programs in the midst of reduced Federal expenditures and control of health funds.

The conferees responded with two general directives: create "incentives" for States and communities to improve adolescent prevention programs, and capitalize on Federal "credibility" in this area, based largely on research knowledge, to guide such activities. They also expressed the feeling that parents' groups and the private sector are invaluable allies in health promotion efforts.

Throughout the conference, participants reported that prevention programs are in a state of potential crisis. If the Federal Government intends to realize its own prevention goals, they said, it must take definite actions to unite disparate public and private groups.

As a first step, they suggested Federal cooperation and participation in State or sub-State level conferences to acquaint interested States and localities with successful models of health promotion and prevention programs for young people and with resources available to fund such programs.

The conferences would be attended by community teams made up of teachers, health workers, parents, interested volunteers, and perhaps young people themselves. Such teams would advise the States on their communities' concerns and needs. Acting on local advice, States then could put existing resources to better use in developing school/community prevention programs.

The success of such a plan of action, the conferees agreed, would depend greatly upon Federal/State/local cooperation, with continued Federal participation.

That participation would have to help foster collaboration between the education and health fields, conferees emphasized. While the two have related goals, they traditionally have not worked well together, as was pointed out by ADAMHA Administrator Dr. William Mayer in his opening remarks.

The workshop itself proved to be a break with that tradition. Six of the fifteen conferees represented school districts and education departments, including Floretta Dukes McKenzie, newly appointed Superintendent of Schools in the District of Columbia.

The educators and health workers were in complete unison on one point: limited public funds will curtail existing programs and obstruct the creation of new ones in both fields. As McKenzie noted, most school administrators would welcome health promotion activities for their students. But few school districts can afford them, as many already are struggling to remain financially solvent.

To circumvent the fiscal barriers, conferees suggested that schools supplement teaching staffs by training parent and citizen volunteers to conduct health education classes.

The health field is in similar fiscal straits, because the new block grant program has reduced current health budgets by 25 percent, it was pointed out. On the other hand, the alcohol, drug abuse, and mental health block grant stipulates that States must spend a portion of the alcohol and drug abuse funds on "prevention and intervention" programs. Several participants expressed hope that this represents a long-awaited national "mandate" for prevention.

However, Federal conferees saw the prevention requirement as more of a stimulant than a mandate. As Roy Davis of CDC pointed out, the law does not define "prevention and intervention." In the face of dwindling resources, he said, the question for States may not be "How many new prevention programs can we fund?" but rather "How many of existing programs can we call 'prevention?'"

Now that the States control health funds, the conferees agreed, the Federal leadership role will entail communication with State agencies involved with prevention. This can be a complex task, many noted, because various components of a State government may be interested in or responsible for prevention programming, including the governor's office, the State legislature, and various State agencies.

Several participants recommended that Federal agencies enlist the aid of special interest groups who can serve as "points of entry" to State systems. As one example, Dr. John Langer of the Drug Enforcement Administration (DEA) reported that his agency benefited from a $400,000 contract it awarded to the National Association of State Alcohol and Drug Abuse Directors. Under the contract, the Association set up meetings across the country between DEA and State officials to explore common interests. The meetings ultimately brought about linkage between criminal justice and community treatment systems in many States, Langer said.

At the same time, the conferees noted, Federal and State officials must encourage local involvement in adolescent prevention programs.

In one discussion group, Joan Houghton of the National Institute of Mental Health (NIMH) identified four typical levels of community interest in the prevention concept: communities that are disenfranchised or too poor to become interested; those that take interest only in response to a crisis affecting their youth; those whose interest is sparked by inspired leadership; and those who become interested spontaneously.

Throughout the workshop, participants debated whether a "comprehensive" or a "specific" approach to adolescent prevention is more likely to succeed. Some pointed out that school programs that tackle a range of teenage health problems can make the most of limited resources and class time. Others argued that, if a general approach seems vague to decisionmakers and advocates, prevention programs will lose their support.

Reporting on his experiences as director of an alcoholism prevention project in the Seattle school system, Clay Roberts emphasized that all health promotion efforts for adolescents have common objectives; namely, to foster the young people's self-esteem and teach them decisionmaking and coping skills. However, from a practical standpoint, Roberts urged prevention workers to "start small" in the planning stages of a school program and consolidate various issues as the program gains ground.

For further information, contact Sidney Wolverton, Director, ADAMHA Division of Prevention, Room 12C-25, Parklawn Bldg., 5600 Fishers Ln., Rockville, MD 20857.

alcohol digest

Alcohol Digest is a collection of items of interest to the alcohol field.

Information Available On 'Other Victims'

A free pamphlet, "The Domino Effect of Alcoholism and Its Impact on Society," is available from The Other Victims of Alcoholism, Inc., (TOVA) a national volunteer public information group dedicated to increasing awareness about the effects of alcoholism on those persons near to or around the alcoholic. Founded in 1976, TOVA has testified at congressional hearings; distributed literature; conducted seminars, workshops, and conferences; led training programs; presented speeches; and placed articles in the popular and scientific media. TOVA is supported entirely by donations.

For a free single copy of the pamphlet or for further information, contact Josie Balaban Couture, The Other Victims of Alcoholism, Inc., P.O. Box 921, Radio City Station, New York, NY 10019.

Baseball Team Institutes EAP

The Chicago White Sox professional baseball team has instituted a program to provide players and front office employees with confidential help for alcohol and drug problems, marital discord, and emotional distress. The team's contract with Parkside Medical Services Corp. of Chicago (IL) calls for counselors to be available 24 hours a day by way of a telephone hotline. Supervisory personnel will be trained to recognize signs of distress and decreased job performance, and employee self-referrals will be encouraged. Family members will also be able to use the program.

For further information, contact Chuck Shriver, Chicago White Sox, Comiskey Park, 324 West 35th St., Chicago, IL 60616.

Seminar Focuses on Puerto Rican Client

The New York City affiliate of the National Council on Alcoholism (NCA) recently sponsored a 1-day clinical workshop on "Treatment of the Puerto Rican Alcoholic Client" that explored atttitudes toward alcohol use and alcoholism in the Puerto Rican community, language issues, needs of the client versus skills of the staff, generational dynamics, and general treatment techniques. Videotapes were used in some sessions, and small discussion groups focused on ways to work with the Puerto Rican family. Approximately 30 persons attended the workshop. For further information, contact Ross Fishman, Ph.D., NCA-New York City Affiliate, 133 East 62nd St., New York, NY 10021.

Group Sponsors Fiscal Workshops

The Center for Public Management in Potomac (MD) is conducting a series of training programs to help State and local grant managers and accountants strengthen fiscal management skills, control costs, and deal with cutbacks in funding. The three-day program, "Accounting for Federal Grants and Contracts," will be presented in New Orleans, Washington, Atlanta, Boston, Chicago, New York, Denver, Anaheim (CA), and Seattle between March and October of 1982. The cost is $295.

For further information, contact Robert Stross, CPA, Center for Public Management, 12713 Steeple Chase Way, Potomac, MD 20854.

University Offers Alcohol Certificate

The University of California at Los Angeles (UCLA) Extension's Department of Continuing Education in Health Sciences and the UCLA School of Medicine, in cooperation with the University of California Statewide Certificate in Alcohol Studies Program, now offers a Certificate in Alcohol/Drug Abuse Studies. The program is designed for counselors, teachers, ministers, and personnel in law enforcement, industry, government, and human service agencies. The certificate requires 15 units of study. For further information, contact Rina Mark, Health Sciences, UCLA Extension, P.O. Box 24901, Los Angeles, CA 24901.

Scholarship Open to Physicians, Students

Physicians and medical students are eligible to apply for the A.E. Bennett Scholarship for Alcohol Studies, which provides for tuition, room, and board at the Physicians Institute, Rutgers Center for Alcohol Studies, New Brunswick (NJ), from June 20 to July 9, 1982. The deadline is March 15, and applicants should write to Claire Osman, American Medical Society on Alcoholism, 733 Third Ave., New York, NY 10017.

Free Taxicab Programs Expand

Free taxicab programs to help reduce needless death and injury from drunk driving have been instituted in several areas. Under Project LIFT (Leave in a Free Taxi), employees of the Government Employees Insurance Company (GEICO) may call a taxi for themselves, a family member, or a friend or party guest who has had too much to drink. The company will reimburse up to $25 of the fare per ride with no questions asked. Approximately 5,000 GEICO employees across the U.S. are eligible for the program.

For the second year in a row, people in the Los Angeles area who had too much to drink during the holidays could leave the driving to CareCab, a free taxicab service sponsored by the CareUnit Hospitals of Los Angeles and Orange County (CA). Supervisory personnel from each hospital staffed the CareCab phone lines on a voluntary basis. This year, the service was expanded to CareUnit Hospitals in Memphis (TN), Miami (FL), St. Louis (MO), and Washington (DC). In Washington, taxi rides were provided to any suburban location for anyone calling from a public place in metropolitan Washington. Calls were answered from 7 p.m. to 3 a.m. from Dec. 21 to Jan. 2.

For further information, contact Gary P. Smith, Manager, Public Information, GEICO Corp., GEICO Plaza, Washington, DC 20076; Stephen Arterburn, CareUnit Hospital of Orange, 401 South Tustin Ave., Orange, CA 92666; or the Providence Hospital CareUnit, 1053 Buchanan St. NE., Washinton, DC 20007.

recent publications

Another Chance. Hope and Health for Alcoholic Families, by Sharon Wegscheider; Science and Behavior Books, Inc., P.O. Box 11457, Palo Alto, CA 94306; 1981; 300 pp.; $12.95. Presents more than 10 years of clinical findings on the dynamics of the alcoholic family and the defensive role each family member plays; presents a treatment philosophy based on a "whole-person model" of the individual, a systems model of the family, and a "family disease" model of alcoholism; proposes a treatment program blending techniques from both alcoholism treatment and family therapy, as well as certain aspects of the AA and Al-Anon philosophies.

Occupational Counseling and Referral Systems, by Lewis F. Presnall; Utah Alcoholism Foundation, 2880 South Main, Suite 210, Salt Lake City, UT 84115; $9.95. The author provides a general history of alcoholism, and discusses cost and prevalence factors, staffing and training issues, and the problems encountered in conducting counseling and making referrals in business, industry, and government work settings.

Alcoholism: The Facts, by Donald W. Goodwin; Oxford University Press, 200 Madison Ave., New York, NY 10016; 1981; 135 pp.; $11.95. According to the author, a book "written for people who worry about drinking, their own or somebody else's," this volume is intended to correct much of the misinformation that exists about alcoholism—such as alcohol's effects on the body, symptoms of and treatments for alcoholism, and the fundamental principles of Alcoholics Anonymous—discussed in nontechnical terms.

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Editor: John Small
Art Editor: Julie Kurz

Mental Health Services to Rural Workers: Strategies, Service Implications and Worksite Utilizations; available from Industrial Social Welfare Center, Columbia University School of Social Work, 622 West 113th St., New York NY 10025; 1981; $5. Summarizes and elaborates on the proceedings of a 1980 conference on issues, ideas, and responses related to mental health services for rural workers. Addresses sociological, strategic, and technical issues, and discusses the idea of confidentiality.

Psychotropic Substances and Their International Control; available from Addiction Research Foundation, 33 Russell St., Toronto, Ontario, M5S 2S1 Canada; 230 pp.; $22.95. Includes the reports and background papers prepared for the 1980 meeting of the same name; recommendations from the meeting were presented to the United Nations Commission on Narcotic Drugs in February 1981. *Statistical Supplement to the Annual Report 1979-1980*; 274 pp.; $12.50. Companion volume to the foundation's annual report. Intended to provide the reader with a broad overview of the nature, extent, and consequences of the use of psychotropic substances in Canada, as well as a brief overview of international trends. *Report of the International Working Group on the Convention on Psychotropic Substances, 1971*; 75 pp.; $4.50. Intended for governments, international organizations, and individuals interested in improving international drug control. Report contains French and Spanish translation of text as well.

Alcoholism: Handicaps on the Road to Recovery; available by writing to Martha Johnson, NCA-Greater Detroit Area, 1800 Kales Building, 76 West Adams, Detroit, MI 48226; $5. Contains copies of presentations made at the fifth annual conference of the National Council on Alcoholism of the Greater Detroit Area. Discusses physical, mental, employment, and service provision handicaps in the alcohol field.

Alcohol Services for Special Populations; available from Community Training and Resource Center, 55 Dimock St., Roxbury, MA 02119; 39 pp., single copies free. Profiles alcohol agencies in Massachusetts having treatment modalities specifically designed to meet the needs of special population groups. Contains information on fees for services, eligibility requirements, and languages spoken at particular agencies.

Alcohol and the GI Tract, ed. by Carroll M. Leevy, M.D.; W.B. Saunders Company Ltd., 1 St. Anne's Road, Eastbourne, East Sussex, BN21, 3UN, England; 502 pp.; contact for price in American dollars. Summary of original research in the area of alcohol and digestive disorders. Highly technical volume intended to answer questions on this subject often raised by medical practitioners and their patients.

audiovisuals

Our Brother's Keeper; color film, 35 min., free loan; a collaboration between Project Cork at Dartmouth Medical School and Operation Cork; available from Modern Talking Picture Service, 5000 Park St. North, St. Petersburg, FL 33709. Depicts a physician's struggle with alcoholism and how it affects him, his family, colleagues, and patients.

Alcoholism: The Bottom Line; 29 min.; sale: $480. Intended for company supervisors, but also applicable for all levels of management. Demonstrates, through a series of vignettes, that supervisors should rely on trained personnel to diagnose alcoholism among their employees.

Drugs and Alcohol; each 28 min.; sale: $405 ea., or all three for $1,000. Three separate films — "Viable Alternatives," "Family and Peer Factors," and "From Use to Abuse," — evaluate reasons for use of drugs and alcohol and examine the concept of "when is it too much?"

meetings

Mar. 21-22. Plymouth, MI. Administrative Symposium. Contact Michigan Alcohol and Addiction Association, 29563 Northwestern Hwy., Suite 7, Bldg. F, Southfield, MI 48034.

Mar 31 - Apr. 2. Detroit, MI. National Alcohol and Highway Safety Conference. Contact Dr. Leroy W. Dunn, Chief, Driver and Pedestrian Education Division, National Highway Traffic Safety Administration, Department of Transportation, NTS14, 400 7th St. SW., Washington, DC 20590.

Apr. 19-May 7. Minneapolis, MN. Training School on Alcohol and Drug Abuse. Contact Mary Simonson, Johnson Institute, 10700 Olson Memorial Hwy., Minneapolis, MN 55441-6199.

Apr. 25-30. Minneapolis, MN. Workshop on Chemical Dependency and Adolescents. Contact Betty Reynolds, Johnson Institute, 10700 Olson Memoral Hwy., Minneapolis, MN 55441-6199.

Apr. 27. Lansing, MI. "Recovery or Repeat." Contact Michigan Alcohol and Addiction Association, 29563 Northwestern Hwy., Suite 7, Bldg. F, Southfield, MI 48034.

May 16-21. Minneapolis, MN. "Treating the Adolescent in Trouble With Alcohol and Drugs." Contact Workshop Coordinator, Community Intervention, 220 South 10th St., Minneapolis, MN 55403.

June 6-ll. Anchorage, AK. National Conference of the Association of Halfway House Programs of North America. Contact AHHAP Office, 786 East Seventh St., St. Paul, MN 55106.

July 19-23. Minneapolis, MN. "Group Facilitators Training Workshop." Contact Workshop Coordinator, Community Intervention, 220 South 10th St., Minneapolis, MN 55403.

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Parent Groups Seen As New Prevention Resource

The impact of prevention programs can be expanded if alcoholism professionals work closely with parent action groups, according to Charles L. Durban, M. Ed., director of training at Eagleville Hospital and Rehabilitation Center in Eagleville (PA).

"The infusion of these parent groups into prevention work has enabled us to stretch our resources, more actively promote drug and alcohol abuse education programs, and find political support for our efforts," says Durban, who has helped to develop eight parent action groups in Montgomery County (PA), population 700,000. "For these reasons, seeing parent action groups as responsive community organizations rather than as a vigilante threat can be a positive way to enhance our own ability to decrease drug and alcohol abuse."

According to Durban, parent action groups have evolved out of a "growing frustration" on the part of parents and a "recognition of the fact that a 'good' home and 'good' parents are no guarantee against substance abuse problems."

Those seeking to form or assist such groups should keep several key issues in mind, according to Durban. First, he says, the groups are — and need to be — parent centered. "As prevention professionals, we should offer suggestions, share our experiences, and help to sort out specific goals and priorities, but we should not tell parents what they should do."

Second, Durban says, different groups may have different needs and objectives. "The groups may vary a great deal in their specific strategies and structures in confronting the common problem of alcohol and drug abuse," he says. "And these differences are important to recognize and accept."

Third, he says, parent action groups must form strong liaisons with other community systems such as churches, school districts, law enforcement agencies, and treatment and prevention programs. "The more we develop the idea of prevention and education programs, the more we see how it must be addressed not only on an individual or small group basis but also on a large group and even societal level."

Durban also says that it is important for parent groups and prevention professionals to work together. For example, he says, parent groups can often accomplish or at least try things that prevention professionals are unable to do, especially in the schools. Also, parent groups can effectively promote the increased use of professional prevention services.

"The great majority of parents are very eager to learn what people working in prevention have to offer. If there are problems and disagreements," Durban advises, "fight them out openly and together and create a compromise position or at least a mutually acceptable agreement that does the most to utilize the resources of each group."

Finally, since most prevention professionals have very limited resources, they should look to parents as a "low cost and readily available source of assistance," Durban says. He estimates that parent groups are now active in almost every State and U.S. territory and says that "for a prevention professional to ignore or downplay this potential is to radically limit the purpose and effectiveness of many prevention programs."

For further information, contact Charles L. Durban, M.Ed., Director of Training, Eagleville Hospital and Rehabilitation Center, Eagleville, PA 19401.

— John Small

Dental Students Target of Training Program

Dental students at the University of Maryland are getting an inside look at alcoholism treatment and intervention by learning to identify and refer to treatment their patients with alcohol problems. Funds are provided through a Career Teacher Grant jointly sponsored by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

NIDA and NIAAA created the Career Teacher Training Program in 1972 in an effort to incorporate drug and alcohol data into the curriculum of medical schools, and to develop a cadre of medical educators capable of teaching this curriculum. Their combined efforts have led to programs being funded in 63 medical schools and in 1 school of public health. The pilot program at the University of Maryland is the first to extend the general Career Teacher Training Program beyond medical, public health, and osteopathy schools.

The Maryland dental program affords prospective dentists the opportunity to do "something we have not been doing," says program coordinator Mark S. Arthur, D.D.S. Students enrolled in the program learn methods of informal questioning that will reveal the extent to which their clients may be involved with alcohol, says Arthur, and students become increasingly sensitized to the patterns of alcoholism. Some 600 dental students and educators will be trained at the university.

Under the guidelines established for the Maryland program, dentists are taught to refer to treatment centers any clients whom they identify as potentially alcoholic. Arthur says that the students have accepted the program with great enthusiasm, taking advantage of what they see as "a chance to practice comprehensive, holistic dental medicine."

For further information, contact Mark S. Arthur, D.D.S., Department of Pharmacology, University of Maryland Dental School, 666 West Baltimore St., Baltimore, MD 20201.

— Jill Vejnoska

Coming In IFS No. 95:

A Special Report On The Public Inebriate

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Jackson State Program Focuses on Minorities

The Interdisciplinary Alcohol and Drug Studies Center (IADSC) at Jackson (MS) State University is currently the only comprehensive alcohol and drug studies program at a historically black college in the U.S. It provides research, education, training, and information on a wide variety of subjects and is beginning to address the special problems of rural, especially minority rural, clients.

According to Program Director Mary Benjamin, Ph.D., the value of the program is threefold: it generates research projects on topics essential for the university's academic programs; it offers a pool of trained individuals and has increased the opportunities for blacks to enter the alcohol/drug/mental health field at a professional level; and it addresses many of the training, prevention, and research needs of the State of Mississippi. Currently, 24 students are enrolled.

The program began in 1974 shortly after Mississippi drew up its first State Plan on alcoholism. At that point, according to Benjamin, an effort was made to pull together the university's alcohol and drug efforts, and a series of six grants helped the IADSC establish an education and training program and prevention activities, begin research on campus drinking, run a public information campaign, and initiate a Minority Access to Research Careers (MARC) honors undergraduate research training program.

The MARC program, funded by the National Institute of Mental Health (NIMH) in 1981, is the newest addition, and involves an interdisciplinary team from the departments of biology, chemistry, sociology, psychology, and health, serving as mentors for five honors students who pursue their regular majors, but take a 12-hour enriched curriculum in alcohol/drug substantive information and research techniques. Students also do a 3-month research internship.

Today, the Center, which has been funded by the Training Branch of NIAAA and the Mississippi Division of Alcohol and Drug Abuse since 1975, is a special program under the Office of Academic Affairs at Jackson State. It serves as an interdisciplinary setting for the study of substance abuse; trains counselors, planners, and administrators; offers a 3-month internship at several agencies and programs for those specializing in counseling, public information, planning, and management; provides primary prevention services; develops and tests theories and research skills; and offers a 36-hour M.A. or M.S. degree in sociology or physical education with a specialty in alcohol and drug studies. The curriculum includes liberal arts, education, business administration, and substance abuse-specific courses. The Center offers a series of short-term training experiences and workshops. For example, the IADSC, through the department of health, hosts the annual Drug and Alcohol Summer Institute; the Minister's Workshop on Alcohol/Drug Education; and the Mississippi Annual School of Alcohol/Drug Studies.

The Center also works with the community, fostering an exchange of services, ideas, and programs. Its 40-member advisory board — composed of citizens from the community, business representatives, and university faculty — locates agencies for placing interns, and assists in curriculum design and ongoing program evaluation. In turn, IADSC provides technical assistance to many State and community programs.

One of the goals of the Jackson State program is to fill knowledge gaps in many areas, including rural alcohol abuse, southern drinking patterns, ethnic minorities and women, and youth and campus drinking practices. In addition, Jackson State's graduates, who have found employment as far away as Indiana and Connecticut, serve as credentialed counselors, trainers, administrators, and planners in numerous area alcohol and employee assistance programs (EAPs), and agencies such as the State motor vehicle administration.

For further information, contact Mary Benjamin, Ph.D., Director, Alcohol and Drug Studies Center, P.O. Box 17054, Jackson State University, Jackson, MS 39217.

— Millree Williams

Church Addresses Needs of Alcoholics

Because he felt there was "a definite need for a place where alcoholics, drug abusers, and their families could worship God," Rev. Dwight Kellar recently founded the Church of the Alcoholic (COTA) in Grand Rapids (MI).

Says Kellar, "We don't want to compete with other churches, but there is a definite need for a place where these people can meet, worship, and share their problems." He especially welcomes family members, saying that "they are sick themselves from living a lie, covering up for relatives, and assuming their responsibilities."

The services are held Sundays at 2 p.m. at the Sunshine Christian Reformed Church in Grand Rapids, a church that Kellar says "is nestled in the woods and can offer the alcoholic a sense of anonymity and serenity." The services are open to the public. COTA is a fully-incorporated church, Kellar says, and is its own denomination.

Kellar knows all too well the problems his parishioners face. He weathered bouts with ulcers, food poisoning, and deteriorating gallstones during his 25 years as a minister at various Churches of the Nazarene in the Grand Rapids area. Eventually, he turned to drugs and alcohol to ease the pain and now he estimates that he was dependent for more than 12 years. Finally, when he lost his position as a minister, he decided to end his alcohol and drug use.

COTA is supported by the offerings of its members, and a bulletin is published every week. Kellar relies heavily on Scripture in his Sunday message, but tries to be flexible because of the more than 25 denominations that are represented. "The services," he says, "are conducted with substance abusers in mind, offering to them, their families, and friends messages based on the Bible that are pertinent to their problems of maintaining sobriety and their sanity. They have the opportunity to worship with others experiencing their problems and hear a message from the Bible with their needs in mind."

For further information, contact Rev. Dwight Kellar, Church of the Alcoholic, P.O. Box 1785, Grand Rapids, MI 49501.

—John Small

Rochester Groups Team Up In Intervention Effort

The only jarring sounds heard at Rochester (NY) rock concerts these days come from the singers on stage, as an innovative program designed to aid substance-abusing concertgoers has virtually eliminated the wail of police and ambulance sirens.

In what has been termed "unusual cooperation," FM rock station WCMF and Rochester's private, nonprofit Drug and Alcohol Council (DAC) have developed and implemented a program aimed at reducing the number of incidents of concertgoers who abuse alcohol or drugs.

Like many other cities that are stops on the rock concert circuit, Rochester has been beset by incidents of property damage, vandalism, stabbing, drug overdose, and drunkenness after performances. According to one police official, an average of eight people had to be hospitalized and four arrested after each concert. "Everyone realized things were going from bad to worse," said Jim Hooley, former WCMF news and public affairs director, "and the people who ran the ambulances didn't really have the expertise to deal with overdoses and so on — they wouldn't know what to do with a kid, say, who'd been mixing downers with alcohol."

Members of the DAC, recognizing the devastating effects that alcohol and drugs — whether taken separately or in combination — can have on teenagers, enlisted the aid of the WCMF staff, city officials, the Rochester police department, and other citizens, and formed Head(s) on Straight (HoS), a nonjudgmental, peer assistance project operated at the city's major concert arena, the War Memorial.

Initially, the DAC considered presenting their concept of an overdose recovery room located right at the War Memorial to city officials. But in the end, according to DAC officials, they took their plan to the War Memorial's management firm, Gladieux Food Service Inc. With Gladieux's help and funding, they set up a recovery room — complete with cots and medical supplies — and recruited experienced personnel as well as volunteers to staff it. HoS now has 130 trained volunteers.

WCMF, meanwhile, provided the impetus for the movement that culminated in HoS, and the radio station continued to support the program as it struggled to become operational. According to Hooley, one distraught listener's complaint about the unpleasant events taking place at the War Memorial during and after concerts prompted another to call in and describe another community's (New Haven, CT) solution to the problem. WCMF approached the DAC with the information, and, says Hooley, "that's where it all began." According to Hooley, WCMF broadcast information about the DAC's program on its regular news shows until "HoS found its feet." With the program off and running, the station has begun devoting its time to persuading major rock personalities to tape drug- and alcohol-related safety spots that can be played when their own schedules bring them to Rochester.

In its first year of operation, HoS helped nearly 800 concert goers without involving the law or medical authorities. In addition, the program has been instrumental in promoting harmony among Rochester's service-providing personnel. One police lieutenant noted that "the city has absolutely no intoxication law" and that "the only thing we could do before HoS was arrest the kids if they plugged up the streets. We didn't want to put these kids in jail," he said, adding that no facilities existed at the police station for caring for overdosed or intoxicated youngsters. Now, he says, "HoS makes our job so much easier; it frees our men to deal with more serious problems. In fact, since HoS started, we probably haven't arrested more than a dozen people for all events, including these rock concerts, and we've noticed a really big drop in the number of kids with drug or alcohol problems resulting from these shows."

According to Dan Schey, DAC director, 86 percent of the patients treated by HoS had been abusing alcohol alone. The remaining 14 percent, he says, were abusing a combination of alcohol and other drugs, or had severe emotional problems.

Schey also says that the number of teenagers treated since the start of HoS has declined. "When we first started, we would treat 25 to 30 persons at a major concert. Now it's more like 10 or 15." Schey says the most important aspect of the program is that it projects a helping image and is nonjudgmental. "We want people to know that if they get in trouble and are abandoned by their friends — which used to happen quite a bit — we will be there. Now, we find teenagers bringing their friends in and asking for help. With teenagers," he says, "the possibility is always there for an overdose or death. It can be a very dangerous situation."

For further information, contact Dan Schey, Director, Drug and Alcohol Council, 396 Alexander St., Rochester, NY 14607.

— Jill Vejnoska

Program for Deaf Offered in Milwaukee

The Milwaukee Council on Drug Abuse, Inc., in cooperation with the Milwaukee Hearing Society, has completed an alcohol and drug abuse prevention program for the deaf. The 6-week "Families, Drugs, and Decisions" program encourages parents and children to work together to develop communication and listening skills as prevention tools.

According to program coordinator Cheryl Olson, there is a need for such programs because "when a deaf alcoholic goes into an alcoholism treatment facility, there are usually no staff members they can communicate with and much of the treatment process is lost." Also, she says, "deaf people are unable to participate in the after-detox phase of treatment since so much of it is based on group therapy and verbal skills."

The classes are open to deaf adults, parents of hearing-impaired youths, children or teenagers with hearing problems, and relatives or concerned friends of deaf persons. The six sessions cost $5, which covers the cost of a manual, "Drug Abuse Is a Family Problem." Interpreters are used, and a series of videotapes is being prepared that, Olson says, "will be made available to the community at large and to agencies and individuals who wish to replicate the program."

Assisting the program financially were the Northshore Kiwanis Club, the Milwaukee Civitan Club, and the Combined Community Services Board of Milwaukee County.

For further information, contact Cheryl Olson, Adult Education and Programs Coordinator, Milwaukee Council on Drug Abuse, Inc., 1442 North Farwell Ave., Milwaukee, WI 53202.

—John Small

Boston Study Probes Needs Of Future Professionals

Future medical and social service professionals may lack motivation to devote professional time to problem drinkers, expressing pessimism about problem drinkers' ability to overcome their problems, according to researchers at The Medical Foundation, Inc., a Boston-based health research and education organization. Foundation researchers, Henry Wechsler, Ph.D., and Mary Rohman, M.A., conducted a mail survey of 1,106 graduate students as part of an NIAAA-funded study to gauge future caregivers' expectations and attitudes regarding the treatment of people with alcohol-related problems. The graduate students were enrolled in schools of nursing, medicine, and social work, as well as in counseling programs in seven major universities in or near the Greater Boston area.

Respondents were questioned about their exposure to alcohol education, their reactions to the disease concept of alcoholism, and their willingness to treat people with alcohol-related problems. In addition, the survey asked the students to rate different types of treatment on the basis of therapeutic effectiveness and to indicate how likely they thought recovery was for most alcoholics.

Approximately one of three students (34 percent) said they felt that few people are able to overcome drinking problems, "even with treatment." Some two-thirds (63 percent) foresaw eventual relapse for alcoholics who achieve sobriety, and about one-half (51 percent) expressed the opinion that alcoholics are seldom able to follow through with treatment plans. In addition, the future caregivers said they did not consider any form of treatment to be a "very good" therapeutic resource for alcoholics; the treatment source most often rated "very good" by the students (73 percent) was Alcoholics Anonymous (AA)—an organization that does not directly involve caregivers in its work.

The study's findings are "discouraging," the researchers say, because of what they suggest about the current state of caregiver training. According to the authors, "The findings raise serious questions about the way in which professional programs are preparing students to deal with alcohol abuse problems." Although most of the respondents said they had been exposed to some type of alcohol education and indicated they agreed with the disease concept of alcoholism, the survey showed that students doubted alcoholics' ability to recover and are reluctant to treat them, the authors said. "Professionals are understandably reluctant to treat clients whose chances for recovery are poor or if they think their skills will not be effective. In other words, if a professional thinks that a problem cannot be solved or that a client cannot be helped, the chances are poor that he or she will respond effectively, if at all, to that client."

Wechsler and Rohman also noted that "a disproportionate number of problem drinkers among help-seekers has been noted at many health and social service agencies. This is because problem drinkers tend to experience medical, psychosocial, and family problems more frequently than nondrinkers or 'normal' drinkers and also because they may seek to avoid that 'alcoholic' label connected with receiving treatment from alcoholism agencies," they said.

However, the authors said, much can be done by professional schools to improve the future responses to problem drinkers. Many resources exist for treating alcohol-related problems, he said, but they need to be carefully evaluated. "Questions of program effectiveness, including what is effective for people with special needs, must be addressed in professional education programs so that the future professionals will have confidence in their professional skills.

"Professional self-confidence and familiarity with alternative resources can serve to generate a more optimistic prognosis for alcoholics, a more positive attitude toward alcoholics as clients, and improvement in the preventive as well as therapeutic impact of future caregivers," they said.

For more information, contact Henry Wechsler, Ph.D., The Medical Foundation, Inc., 29 Commonwealth Ave., Boston, MA 02116.

—*Jill Vejnoska*

Cost Savings Plan Tested in Minnesota

St. Mary's Rehabilitation Center, a 250-bed freestanding treatment facility in Minneapolis (MN), and Blue Cross/Blue Shield of Minnesota have developed a 2-year pilot program designed to provide cost savings to patients needing special assistance during treatment for alcoholism or chemical dependency. "Outpatient Plus" is an attempt to develop a cost-effective therapy for patients who do not require hospitalization, but whose home environment would be either detrimental or nonsupportive to the patient while in treatment. "Outpatient Plus" patients come in daily for outpatient treatment and then rent overnight guest rooms at the rehabilitation center for a minimal cost that Blue Cross/Blue Shield has agreed to pay.

The total cost of "Outpatient Plus" is $68 per day (Monday through Friday) and $24.70 per day on weekends. That compares with $110 a day for inpatient treatment. For further information, contact Patricia Gurska, St. Mary's Rehabilitation Center, 2512 South Seventh St., Minneapolis, MN 55454.

Growth of For-Profit Treatment Centers Cited by Paper

In the last 10 years, the for-profit business of treating alcoholics has become a $300 to $400 million-a-year industry that is growing 50 percent annually, according to an article in the *Wall Street Journal* (October 19, 1981).

It's a case of "classic American business strategy: find a need and fill it," says Robert R. Whiton, senior vice president of Advanced Health Systems, Inc., which operates 20 alcoholism treatment hospitals. "Alcoholism treatment simply wasn't being taken care of adequately by the public or nonprofit sectors," he says.

Two factors have helped proprietary treatment centers grow, according to the *Wall Street Journal*. One is the increasing acceptance of alcoholism as a treatable disease, not a moral problem. The other is the growth of corporate employee assistance programs.

The *Journal* reported that many companies are willing to pay for all or part of the alcoholism treatment because it is cheaper than hiring and training replacements. Firestone Tire and Rubber Company says it saves $2 million annually because its employee assistance program leads to less absenteeism and tardiness, fewer sick days, and improved worker productivity.

Sobriety Clubs in Japan Aid Treatment

Self-help groups or "sobriety clubs" that meet in the cities, towns, and villages of Japan have quietly revolutionized alcoholism treatment in that country in the past 14 years, according to Takeo Fukuda, M.D., Director of the Department of Psychiatry at the Matsue Red Cross Hospital in Matsue City, Japan. The groups are patterned after those of Alcoholics Anonymous (AA), yet remain uniquely Japanese, said Fukuda, who spoke at the National Institute on Alcohol Abuse and Alcoholism (NIAAA) as part of a research exchange program.

Fukuda founded the first community sobriety society in 1967 in Matsue City, the capital of rural Shimane prefecture, 1 of 47 geographical areas in Japan. Today there are 52 community clubs with more than 450 members in the 59 cities, towns, and villages in the prefecture. According to Fukuda, 88 percent of the cities, towns, and villages in the prefecture have organized their own clubs.

The community sobriety clubs are an outgrowth of hospital-based sobriety clubs developed in Japan in the 1960s. Unlike AA, sobriety club members make their names, addresses, and occupations known to the outside world. "The general public in Japan does not consider alcoholism a sin," Fukuda said.

Although there is no specific reference to a "higher power," as in AA, the clubs emphasize the need for improvement of the self, he said. The clubs are generally organized with cooperation from the medical profession, and family members are expected to take part in the activities.

The emphasis on community and family involvement is new in Japan, Fukuda said. Prior to World War II treatment for alcoholism was largely confined to hospitals, Fukuda said. A temperance society had been started in 1853, and an abstinence movement — inspired by activities in the U.S. — flourished temporarily but collapsed with the country's defeat in 1945.

In the 1950s, two sobriety societies were combined to form the All Nippon Sobriety Association (ANSA). In the 1960s, physicians began to actively seek better treatment methods as they became frustrated with the ineffectiveness of drug therapy and patient isolation. Physicians then began to collaborate with patients to form hospital-based sobriety clubs.

According to Fukuda, however, the hospital-based clubs had certain limitations. "If we trusted too much to this method, the patient would rely too much on the doctor and would eventually lose the desire for self-help approaches," he said. "Moreover, there would be strong resistance to attending meetings held in a mental hospital."

Fukuda started the first community-based club with the assistance of staff in three mental hospitals in Matsue City. Since then, the Shimane method of treatment has been adopted by the ANSA as its fundamental policy. Today, ANSA is composed of 293 clubs and 42,000 members throughout Japan.

Fukuda studied 110 of his patients for 5 years as part of an effort to evaluate the Shimane approach. Most of the patients were 40 to 49 years old, and 89 percent had a clinical history of previous physical or mental problems. Sixty-three patients lived outside the hospital and came in periodically for treatment, 47 had been hospitalized for 3 months, and all 110 were advised to join sobriety clubs. Of the 54 who chose to rely solely on medical treatment in the hospital, only 1 remained sober. However, 27 of 56 patients (48.2 percent) who joined the clubs and continued to attend meetings have abstained from drinking (after five years), Fukuda said.

"I can say that the most effective method of treating and preventing alcoholism is not only to treat the patients within the hospital bounds, but also to attach more importance to the role of community clubs, where they can continue to attend the club meetings even after their treatment," he said. "I think one of the reasons for the high average is that in Shimane there are clubs in almost all cities, towns, and villages, and if the members wish, they can attend the meetings almost every night. I firmly believe that the prospect of a bright future in the treatment of alcoholics will be obtained from the nationwide development of our Shimane style approach," he added.

For further information, contact Takeo Fukuda, M.D., Director, Department of Psychiatry, Matsue Red Cross Hospital, Matsue City, Japan.

— Nancy Johnson

Newspaper Supplements Discuss Alcohol Abuse

The *Philadelphia Inquirer* recently produced two special supplements with the theme of "Alcohol and Drug Abuse: A Family Matter." The supplements, which were distributed free with the day's newspaper, contained seven pages of articles on various aspects of alcohol and drug abuse, plus one page of advertising by hospitals, treatment centers, and employee assistance programs. According to Sales Development Representative Larry Malloy, more than 435,000 supplements went out to readers on October 5, 1981, and again on December 28, 1981.

There were two reasons for development of the sections, according to Malloy. "First, we believe we have a responsibility to heighten peoples' awareness about alcohol and drug abuse and abusive behavior. And, second, we looked at these projects as ways of stimulating new business and developing new markets." Malloy says that response to the sections was good, with people "calling for 2 to 3 days asking for additional copies, and advertisers saying that they had seen noticeable activity after the sections went out." Several school systems requested bulk copies of the supplement to use in curriculum development, Malloy said.

The advertising/marketing department of the paper retained control over the project, and the emphasis was on selecting "generic" materials that would be easily understandable to the lay reader. The project was a success, Malloy said, and the supplements may become an ongoing — possibly quarterly — project. He adds that December 28 was chosen for the release of a supplement because the holidays are often seen as a particularly stressful season for alcoholics.

For further information, contact Larry Malloy, Sales Development Representative, *The Philadelphia Inquirer*, 400 North Broad St., Philadelphia, PA 19101.

—John Small

alcohol digest

Alcohol Digest is a collection of items of interest to the alcohol field.

New York State Revises DWI Laws

The State of New York has made major revision in its DWI laws. Under legislation that became effective November 28, 1981:

- A first conviction for driving while ability impaired (DWAI) — blood alcohol content of .07 or above — is punishable by a fine of $250 or imprisonment for not more than 15 days, or both.
- A first conviction for driving while intoxicated (DWI) — blood alcohol content .10 or above — is punishable by a fine of $350 to $500, or imprisonment for not more than 1 year, or both.
- Penalties for repeat offenders in both categories have been increased.
- Counties may use fine revenues to develop comprehensive "Special Traffic Options Programs" (STOP-DWI). To participate, a county must designate a coordinator who will submit a county STOP-DWI plan to the commissioner of the State department of motor vehicles. Upon approval, fine revenues can be used to pay for enforcement, adjudication, education, rehabilitation, and other related activities at the county level. For further information, contact Madeline Lewis, New York State Division of Alcoholism and Alcohol Abuse, 194 Washington Ave., Albany, NY 12210.

Video Series Focuses on Alcohol

The University of Mid-America has produced a video series entitled *Loosening the Grip: A Survey of Alcohol Information.* The series provides a survey of basic information on alcohol use and problems, prevention, intervention, treatment, and the role of the family, and is targeted to alcoholism counselors, health care professionals, recovering alcoholics, students, and community service groups. The 11 half-hour sessions are hosted by E.G. Marshall and are available on videocassette for purchase or rental.

The series has been presented as a for-credit course by several colleges and universities, with a textbook and discussion meetings. For further information, contact Larry Aerni or Kitty Kilmer, University of Mid-America, P.O. Box 82006, Lincoln, NE 68501.

Hospital Offers Christian Therapy

A Christian-oriented therapy program for the alcoholic is available to patients at the CareUnit Hospital of Los Angeles, a licensed medical/surgical facility that specializes in the treatment of adults and adolescents with alcoholism and other chemical dependencies.

According to Program Administrator Tom Vurgason, "For the Christian, living in today's world can present many conflicts and problems. Sometimes, when he or she turns to alcohol and other chemicals for solutions, an intensive therapeutic program with emphasis on spiritual support systems is needed." Christian therapy is provided only to those patients who request this approach, Vurgason said. All patients also participate in therapy administered by a multidisciplinary treatment team. For further information, contact Sonny Walker, CareUnit Hospital of Los Angeles, 5035 Coliseum St., Los Angeles, CA 90016.

Youth Alcohol Series Cited

A series of articles exploring alcoholism and alcohol abuse by teenagers recently won its reporter the 1981 Jay S. Lewis Journalism Award, presented annually by the National Association of Alcoholism Treatment Programs to a journalist who has made an outstanding contribution to the public understanding of alcoholism and its treatment. This year's award went to Elaine Stamper of Odessa (TX), whose week-long series in the Las Cruces (NM) *Sun-News* focused on the various harmful forms of teenage drinking and included extensive interviews with teens, their parents and teachers, law enforcement officials, and treatment and intervention professionals. For further information, contact the National Association of Alcoholism Treatment Programs, 17861 Cartwright Rd., Irvine, CA 92714.

College Offers Alcohol Courses

The Rehabilitation Counselor Training Program at Springfield (MA) College offers a concentration in alcohol and substance abuse studies that leads to a master's degree or certificate of advanced study in rehabilitation counseling. The program combines classroom work with research and a clinical component and/or internship. For further information, contact Joseph Stano, C.R.C., Assistant Professor, Rehabilitation Counselor Training Program, Springfield College, Springfield, MA 01109.

Group Planning Alcoholism Registry

Plans are underway to develop a national alcoholism personnel registry to facilitate communication among persons in the alcoholism field and those who need access to alcoholism information, such as insurers. Categories will include administrators, consultants, program directors, supervisors, counselors, and psychotherapists. The deadline for application is June 30, 1982.

For further information, contact Thomas R. Burns, Executive Director, Alcoholism Consultant Services, 13602 North 50th Pl., Scottsdale, AZ 85254.

School Instituted For DWI Offenders

The American Institute of Alcoholism Studies, the educational and research arm of the American Council on Alcoholism (ACA), Inc., has instituted a new professional school for DWI offenders. The Driver Alcohol Training and Evaluation School (DATES) includes five educational sessions, plus a psychological evaluation of each participant, and some counseling. There is also a letter to the referring source (judge or lawyer) which summarizes the client's diagnosis and gives recommendations for future disposition.

The ACA, with its national offices in Baltimore, is a nonprofit volunteer health organization with affiliates in the U.S. and foreign countries. For further information, contact Reverend Alex P. Hurt, or Thomas N. Walker, Executive Director, American Council on Alcoholism, Inc., Suite 16-B, 300 East Joppa Rd., Baltimore, MD 21204.

meetings

APRIL

Apr. 4–6. Jackson, MS. National Conference on Rural Primary Care. Contact Carrie Samuel, Conference Coordinator, NRPCA, P.O. Box 1211, Waterville, ME 04901–1211.

Apr. 15. El Paso, TX. "Pathophysiology of Alcoholism." Contact Rita Chrane, Office of Continuing Medical Education, Texas Tech University Health Sciences Center, Lubbock, TX 79430.

Apr. 19 – May 7. Minneapolis, MN. Training School on Alcohol and Drug Abuse. Contact Mary Simonson, Johnson Institute, 10700 Olson Memorial Hwy., Minneapolis, MN 55441–6199.

April 23–24. Chicago, IL. Illinois Industrial Social Workers Conference on Employee Assistance Programming. Contact NASW, 30 North Michigan, Suite 1410, Chicago, IL 60602.

Apr. 25–29. Midland, MI. Midwest Conference on Alcohol and Drug Abuse. Contact James R. Tarrant, Director of Medical Education, Bay Medical Education, 615 Ninth St., Bay City, MI 48706.

Apr. 25–30. Minneapolis, MN. Workshop on Chemical Dependency and Adolescents. Contact Betty Reynolds, Johnson Institute, 10700 Olson Memorial Hwy., Minneapolis, MN 55441–6199.

NIAAA Information and Feature Service (IFS) is a service of the National Institute on Alcohol Abuse and Alcoholism. The opinions expressed in the articles do not necessarily reflect the view of NIAAA.

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Editor: John Small
Art Editor: Julie Kurz

MAY

May 3–21. Baton Rouge, LA. Three Week School on Addiction Studies. Contact Duncan A. Rose, Baton Rouge Chemical Dependency Units, Inc., 3968 North Boulevard, Baton Rouge, LA 70806. (Course repeated July 5–23, August 2–20, and October 4–22).

May 5–7. Reno, NV. Midwest-Western Regional Conference. Contact Eric G. Scharf, Alcohol and Drug Problems Association, 1101 15th St. NW., Suite 204, Washington, DC 20005.

May 9–13. Minneapolis, MN. Another Chance: Hope and Health for the Alcoholic Family. Contact ONSITE Training and Consulting, Inc., 1645 Hennepin Ave., Suite 206, Minneapolis, MN 55403.

May 10–14. Minneapolis, MN. Intervention Skill Development Workshop. Contact Jan Winsand, Johnson Institute, 10700 Olson Memorial Hwy., Minneapolis, MN 55441–6199.

May 12–14. Colorado Springs, CO. Second Spring Conference for Nurse Educators in Alcohol and Drug Abuse Nursing. Contact Mary Durand Thomas, Alcohol and Drug Abuse Nursing, SC–78, School of Nursing, University of Washington, Seattle WA 98195.

May 14–15. Washington, DC. Fourth Mid-Atlantic Regional Conference on Alcoholism: Adolescent Substance Abusers and Their Families. Contact Audrey Cannamela, The Psychiatric Institute Foundation, 4460 MacArthur Blvd. NW., Washington, DC 20007

May 16–21. Minneapolis, MN. Chemical Dependency and Family Recovery Workshop. Contact Betty Reynolds, Johnson Institute, 10700 Olson Memorial Hwy., Minneapolis, MN 55441–6199.

May 27–30. Philadelphia, PA. National Conference on Alcoholism and the Family. Contact Chit Chat Foundation, P.O. Box 277, Wernersville, PA 19565.

JUNE

June 2–5. River Forest, IL. Continuing Education Program on Addiction. Contact Stella M. Nicholson, C.A.C., or Mary E. Wannop, Central States Institute of Addiction, 120 West Huron St., Chicago, IL 60610.

recent publications

Spirits of the West: Rapid Growth and Drinking, prepared by Alma Lantz, Ken Harmon, and Vickie Eaton; Denver Research Institute, University of Denver, Denver, CO 80208; 1981; 50 pp. and appendices. A report to NIAAA on the increase in alcohol-related problems in western communities undergoing rapid growth; determines conditions that might enhance community design and implementation of previous programs.

Available from the National Association of Gay Alcoholism Professionals (NAGAP), 204 West 20th St., New York, NY 10011: *NAGAP Bibliography: Resources on Alcoholism and Lesbians/Gay Men*; revised 1981; 20 pp.; $2.50. A comprehensive listing of papers and articles — both published and unpublished — that deal with the subject of alcoholism and, in particular, how it relates to homosexuality; *1981 Directory of Facilities and Services for Gay/Lesbian Alcoholics*; 26 pp.; $2.50. Expanded from previous 9-page version, this directory lists gay/lesbian-sensitive facilities and services in 32 States, Washington, DC, and the West Indies.

The Way Back: The Stories of Gay and Lesbian Alcoholics, available from the Gay Council on Drinking Behavior, Whitman-Walker Clinic, Inc., 2335 18th St., NW., Washington, DC 20009; 1981; 90 pp.; $5.40; bulk prices also available. This book highlights the lives of 10 gay alcoholics who found help through the fellowship of AA; includes suggestions for further reading.

Available from Addiction Research Foundation, 33 Russell St., Toronto, Ontario, Canada M5S 2S1: *Training Guidelines and Workbook for the Behavioral Management of Intoxicated and Disruptive Clients*, by Ann E. Cox; 1981; 58 pp.; $7.95. Divided into two sections, the manual presents precourse planning considerations, case material for participants, and suggestions and lesson plans for instructors; *Substance Abuse Book Review Index*, by Jane Bemko, M.L.S.; 1981; 56 pp.; $6.95. Cites reviews that appeared in the 1980 edition of the index, as well as material contained in 81 additional journals.

Victim Assistance and Crisis Line; order from: VAC MANUAL, SoJourner Truth Center for Women, P.O. Box 164, Caruthersville, MO 63830; 1981; 78 pp.; $4.00. Designed to assist volunteers training to work with a small town/rural area crisis line, victim assistance program, or women's center.

Employing the Disabled: What Are Self-Help Groups and What Assistance Can They Offer the Employer? by Rami Rabby; order from 136 East 55th St., Suite 8E, New York, NY 10022; 1981; pamphlet; $5.50. Defines disabled self-help groups and distinguishes between them and other organizations and agencies in this field; explains how employers and self-help groups can work together to identify and recruit disabled employees and remove barriers—architectural, as well as attitudinal—to their employment. Contains appendices listing more than 100 disabled self-help organizations, most of which are national in scope.

Dictionary of Counseling Techniques and Terms, by Frederick D. Harper, Ph.D.; Douglass Publishers, Box 3270, Alexandria, VA 22302; 1981; 62 pp.; $4.95. Contains more than 500 definitions that will be of use to beginning as well as to experienced counselors. Includes a complete reference list, organized by techniques, an appendix relating techniques and terms to various theories of counseling and psychotherapy, examples of popular verbal techniques used in counseling, and exercises for readers.

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Complex Issues Surround Services to Public Inebriates

The Public Inebriate

A Special Report

Who is the American public inebriate? Profile data collected by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) indicate that the urban public inebriate is typically a 45-year-old white male, unemployed, with 9 years of education, divorced or never married, homeless, receiving no public assistance, and having a prior arrest for drunkenness and/or prior admission to a treatment program or detoxification center. This group is estimated as constituting 3 to 5 percent of the Nation's problem drinkers, or 300,000 to 500,000 people.

Although this group is small, the problems it creates are not. According to the National Coalition for Jail Reform (Jail Coalition), one of a number of public and private groups active in this area, one of every three misdemeanor arrests in the U.S. is for public intoxication, and the cost of arresting, booking, jailing, and trying the public inebriate is well over $500 million per year.

For most of America's public inebriates, life is a revolving door between the jail, the courtroom, and the street. Statistics show that the average person arrested for public inebriety has been arrested 12 times before. In 1979, there were 1.173 million arrests in the U.S. for drunkenness and hundreds of thousands of related arrests for loitering, vagrancy, disorderly conduct, and other offenses.

The burden this places on the criminal justice and penal systems is immense. First, the Jail Coalition estimates that it costs $50,000 to build each jail cell in the U.S. and $10,000 per year to maintain each person in jail. Second, the time and effort invested in jailing public inebriates limits law enforcement officers' ability to respond to violent crimes. And, third, it is estimated that 15 percent of the jails in the U.S. are under court order to remedy inadequate conditions — most commonly, overcrowding and deficient medical services.

Cities and States have approached these problems in different ways (see story, p. 2). Thirty-three States plus the Virgin Islands have decriminalized public intoxication and adopted (in whole or in part) the Uniform Alcoholism and Intoxication Treatment Act, which made it possible for them to receive Federal incentive grants to provide public inebriate services. Now, with these funds folded into the Alcohol and Drug Abuse, and Mental Health Services block grant, State legislatures will debate the future of treatment for public inebriates in their own localities.

The issues they will find are complex. For example, can public inebriates decide what is in their own best interest, or should society be able to force the public inebriate into treatment? Are public inebriates the responsibility of the criminal justice or of the health care system? Is the public inebriate the same as or fundamentally different from other alcoholics or problem drinkers? If he or she is fundamentally different, then should treatment approaches be fundamentally different from those applied to persons found to be problem drinkers in driver education programs, employee assistance programs, and other settings? (see stories, pp. 4-7). Many unanswered legal issues also surround the public inebriate (see story, p. 3).

Two major conferences have focused national attention on the problem. In 1980, the First National Conference on the Public Inebriate — sponsored by the Jail Coalition, the National Council on Alcoholism (NCA), and NASADAD — brought together public and private officials in Racine (WI) for a discussion on the policy, economic, social, legal, and treatment aspects of the issue. The general strategy developed by the participants included expanding the existing body of knowledge on the public inebriate, compiling and disseminating information on successful programs, and developing solutions to the problem.

In 1981, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) sponsored a meeting on "Public Inebriate Issues" in Washington (DC). Again, representatives of Federal, State, and local agencies were joined by leaders in the private sector, and the following agenda items were agreed upon: that primary responsibility for dealing with public inebriate issues was at the local level; that comprehensive public inebriate programming needed to be incorporated into the local planning processes; and that further research was needed.

In short, public inebriety is a complex problem that has not been solved and shows no signs of going away. As Sheila Blume, M.D., director of the New York State Division of Alcoholism and Alcohol Abuse, noted at the NIAAA conference, "The alcoholism field has been attempting to forge a constituency around alcoholism treatment needs, but has focused on the 'other 95 percent' because of public misconceptions about alcoholism, and because of its desire to promote intervention at an early stage of alcoholism when prognosis is most favorable. In educating the public, I think it is time that we put in some extra effort to address the serious problems of the sickest alcoholics, who are often public inebriates."

For further information, contact Judith Johnson, Executive Director, National Coalition for Jail Reform, 1828 L St. NW, Suite 1200, Washington, DC 20036; Donald Murray, Director, Criminal Justice Program, National Association of Counties Research Foundation, 1735 New York Ave. NW., Washington, DC 20006; Timothy B. Flynn, Center for Law in the Public Interest, 10951 West Pico Blvd., Los Angeles, CA 90064; Nancy Record, National Association of State Alcohol and Drug Abuse Directors, 918 F St. NW., Suite 400, Washington, DC 20004; Judy Wicks, National Council on Alcoholism, 733 Third Ave., New York, NY 10017; or Diana Tabler, National Council on Alcoholism Public Policy Office, 1100 17th St. NW., Suite 710, Washington, DC 20036.

— John Small

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The Public Inebriate

State Approaches

States Seeking Solutions To Public Policy Questions

The issue of public intoxication is one that affects both the human services and the criminal justice resources of States and communities. Although the majority of the States have decriminalized public intoxication, no single solution for meeting the needs of this population has emerged. In some States, the emphasis has been on providing long-term treatment and rehabilitation, while others have sought less expensive or philosophically different ways to address the public inebriate issues. The following descriptions highlight the diversity of approaches in five States.

FLORIDA

One of the first States to decriminalize public inebriety, Florida moved quickly to develop a wide range of comprehensive rehabilitation services. Existing halfway houses were used to treat public inebriates and new detoxification and outpatient treatment components were established, according to Donald Kribbs, supervisor of Program Planning and Development at the Florida Alcohol, Drug Abuse, and Mental Health Program Office. In addition, Florida utilized its existing community mental health system.

Today, there are approximately 38 comprehensive programs incorporating detox, residential, and outpatient treatment components. Initially funded by State and Federal Uniform Act funds, Kribbs says that today they are funded by Federal block grant funds, State funds, and local funds.

Officials in Florida have also been able to cultivate a high level of cooperation among the social service system, the criminal justice system, and the legislature. Florida law requires police to take anyone publicly incapacitated, or lacking the mental capability to decide if he or she needs treatment, to the nearest treatment center.

Florida's activities on behalf of the public inebriate started in the early 1950s when, according to Kribbs, legislation established a treatment system that included the Florida Alcoholism Treatment and Research Center and five regional outpatient treatment centers in Pensacola, Jacksonville, Orlando, Tampa, and Miami. More recently, Florida has developed long-term residential centers in Tampa, Jacksonville, Miami, and Sarasota. The centers are residential, and clients are encouraged to work (either inside or outside) to defray some of the costs. "This type of program," says Kribbs, "has been most successful with public inebriates; because it is low key, it allows the chronic inebriate time to adapt and to avoid stressful situations, and attempts to provide a more protective environment."

In the 1960s, says Kribbs, activists in the Florida alcoholism movement began developing community treatment centers. "So by 1970, when NIAAA was established, we were ready to effectively use whatever new resources came our way," says Kribbs. "Our early start, our utilization of community resources, and a legislature progressive in dealing with alcohol and drug issues," he says, "got the ball rolling and has kept it rolling."

CONNECTICUT

Connecticut decriminalized public intoxication in 1974, but stipulated that the law would not go into effect until June of 1976. Thus, the State agency was given time by the legislature to establish a range of services. Assisted by Federal grant monies under the Uniform Act, Connecticut set up three freestanding detoxification centers, gave alcohol incentive grants to nine hospital emergency rooms, funded two long-term care facilities (one rural and one urban), and continued support of the State halfway house system. Four State mental hospitals also continued to treat alcoholics.

The major problem in Connecticut, says Donald J. McConnell, executive director of the Connecticut Alcohol and Drug Abuse Commission, was not one of service availability, but one of general attitude toward the public inebriate. When services for the public inebriate were shifted from the criminal justice system to the health care system, he says, the "revolving door" was suddenly in hospital emergency rooms rather than in "drunk tanks." And, McConnell says, "emergency rooms are understandably reluctant to deal with clients who are often disruptive and, at best, disheveled." Furthermore, he says, treatment professionals can be discouraged by the nature of addiction, which often includes relapse. "Thus, the public inebriate can bounce from the hospital emergency room to a freestanding treatment facility to a mental hospital and back to the street where they are picked up by the police and brought back into the treatment system."

McConnell says his experiences since 1976 indicate that States intending to decriminalize public intoxication need to ensure that a training system is in place for police as well as for health professionals. Another important issue, he says, is how to transport the public inebriate to a treatment facility. Connecticut, for example, has developed a van service operating out of local alcoholism councils, many times with the help of volunteers. McConnell estimates that this type of service is about one-quarter the cost of using ambulances. McConnell also feels that a system of soup kitchens, shelters, and long-term nonmedical facilities needs to be developed.

Connecticut's experience with a long-term care facility in Lebanon (CT), a rural area, has been positive, he says, adding that all of the clients referred to Lebanon Pines had been in and out of "medical detoxification facilities" year after year. "That means multiple admissions spending one or two days in a facility charging up to $220 per day. In Lebanon Pines, however, the average stay of this population over the past year and a half has been three-and-a-half months at $25 per day," McConnell says.

CALIFORNIA

California has not decriminalized public intoxication. "Instead," says Charles G. Stribling of the California Department of Alcohol and Drug Programs, "we have the Dukmejian Act, which gives each county the option of decriminalizing public inebriety if they have the appropriate social services in place."

Stribling says the feeling in California is that alcoholism is only a part of the wide range of problems affecting this population. Stribling believes that most skid row residents have reasons other than alcoholism for being there — such as mental illness, escapism, availability of cheap food and housing, or rebellion. According to Stribling, the assumption that all skid row people are alcohol or drug abusers is mistaken. "Fifty percent don't drink at all, 25 percent drink moderately, and the other 25 percent drink heavily," Stribling says. Consequently, he feels agencies must deal with the poverty-related problems of this population first. The basis for this approach rests, at least partly, on findings from a State-funded public inebriate demonstration project in one large county, Sacramento, and one small county, Humboldt. The project was designed to reduce the visibility and number of arrests of public indigent alcoholics, to reduce the time spent on processing these individuals in the criminal justice system, and to increase the number entering the program and successfully addressing their alcoholism problems.

The project provided a "continuum of services" in Sacramento that included a 24-hour drop-in center; a courtesy patrol made up of a van and counselors who patrolled targeted areas; a screening and evaluation center with an "extended sleep off" unit; two detox centers, both social model and modified medical model; a 30-day primary recovery home; a 3-month long-term recovery home; and a nonresidential sober activities center offering supportive, recreational, and vocational services. In Humboldt the project provided a drop-in center; a screening and evaluation unit; a social detox center; a women's recovery home; a sheltered workshop; and a 30-day residential program (added later).

According to Stribling, the 2-year project found that a program based on voluntary admittance was not always effective; that the social model of detoxification was as effective as the medical model and was much less expensive; that referring patients to other agencies to solve multiple problems was not always effective; and that neither of the projects had the authority or the resources to take care of the public inebriates' non-alcohol-related needs for food, shelter, and other necessities.

The findings, according to Stribling, suggest that services for public inebriates must address a variety of needs, not only alcohol and drug abuse, and that basic services need to include a drop-in center, transportation, temporary shelter, a social detox center, and a coordinated voluntary treatment program. The entire evaluation of the project is available in *Drunk in Public: An Evaluation of California's Public Inebriate Demonstration Project* from the State of California Department of Alcohol and Drug Programs, 111 Capitol Mall, Sacramento, CA 95814.

NEW YORK

"In New York," according to Lloyd Simmons, coordinator of Emergency Care at the New York State Division of Alcoholism and Alcohol Abuse, "we have developed several model programs that are community and client specific. We know that there are numerous dynamics interplaying with each public inebriate. To the outsider, public inebriates may look alike, but each has his or her own set of problems that brought them to that point. Some drank their way up and some drank their way down." Recognizing that not all public inebriates who are detoxified want to participate in rehabilitation, "our programs are designed to save and prolong lives in order to give people the opportunity to determine what they want to do with their lives," he says. He adds that service providers and counselors are there to motivate and provide services when they are needed. In New York State, programs serve clients in cities like New York, Albany, Rochester, and Buffalo as well as rural areas. There are 32 emergency care programs statewide and most are nonmedical, with services ranging from a 40-bed emergency care center to a 5-bed emergency unit in a rural hospital to a mobile outreach service. And, according to Simmons, several themes run through each of the programs: incorporating the public inebriate into the mainstream of health services; using emergency care effectively; and deploying models that pull together police, the community, and the emergency care network to increase crisis intervention services. "We know that programs cannot serve all needs of all people, so we try to link persons to services as they are needed," says Simmons.

MICHIGAN

Michigan originally dealt with public inebriates by developing cooperative agreements with several designated general hospitals (with emergency rooms), directing public inebriates there, and reimbursing the hospitals for costs they could not secure elsewhere. According to Kenneth Eaton, Administrator of the Michigan Office of Substance Abuse Services, today Michigan has changed its approach, relying on residential treatment centers capable of providing nonmedical detoxification. Also, Michigan law requires police to take all public inebriates to either an emergency care facility or one of the residential centers.

For further information on activities in these States, contact: Donald Kribbs, Supervisor of Program Planning and Development, Florida Alcohol, Drug Abuse, and Mental Health Program, 1323 Winewood Blvd., Tallahassee, FL 32301; Donald McConnell, Executive Director, Connecticut Alcohol and Drug Abuse Commission, 999 Asylum Ave., Hartford, CT 06105; Charles G. Stribling, Quality Assurance Section, California Department of Alcohol and Drug Programs, 111 Capitol Mall, Sacramento, CA 95814; Lloyd Simmons, Coordinator of Emergency Care, New York State Division of Alcoholism and Alcohol Abuse, 194 Washington Ave., Albany, NY 12210; Kenneth Eaton, Administrator, Office of Substance Abuse Services, 3500 North Logan St., P.O. Box 30035, Lansing, MI 48909.

— Milree Williams

Many Legal Issues Remain Unanswered

Many unanswered legal issues also surround the public inebriate. For example, according to Donald Murray, director of the Criminal Justice program at the National Association of Counties Research Foundation in Washington (DC), some administrators and county civil attorneys believe it is "simply a matter of time before public inebriates file suit against local governments, alleging improper jailing and treatment, with large financial penalties being sought." Already, numerous lawsuits — called "1983 suits" because they are based on Volume 42 of the U.S. Code, Section 1983 — have been lodged against local governments alleging Federal civil rights violations. According to a Supreme Court ruling in 1978 in the case of *Monell* v. *City of New York Department of Social Services*, local governments can be held liable as corporate entities for the actions of their employees and agencies for the denial of civil rights to due process, equal protection, and freedom from the infliction of cruel and unusual punishment including, for example, inadequate medical care in jail. A more recent (*Owen* v. *City of Independence*) ruling eliminated the "good faith" immunity defense for local governments, and in June 1981, the Supreme Court ruled out punitive damages in such cases, but upheld the rights of individuals to sue for compensatory damages.

Adds Murray, "Beyond these growing numbers of suits, medical care in local jails is getting increasing attention, as is the suicide rate among the public inebriate population. These factors will most likely put very strong financial pressures on localities to find alternatives to jail for public inebriates, or to seriously upgrade local medical facilities for the public inebriate."

The Public Inebriate

Treatment Approaches

Manhattan Bowery Project Offers Range of Services

The Manhattan Bowery Project (MBP) has been working to reduce the human and social costs of public intoxication in New York City's skid row area since 1967.

The area had long been home to thousands of men who spent their days drinking and panhandling, living in flophouses, relying on social services for food, and enduring periodic arrests for drunk and disorderly behavior. In an attempt to reduce the burden on the city jails and police force and to offer more humane treatment, 12 beds were set up in a central facilty to provide shelter and detoxification services. The police officer and the rescue aide who cruised the area asking Bowery men if they would like to detoxify often received an enthusiastic "yes."

"It was the first program to try to offer treatment to the public inebriates as an alternative to jail," said Edward Geffner, MBP director. Today the facility has grown into a 48-bed medical detoxification unit, and a social detoxification unit has been added. The Manhattan Bowery Project also has instituted a variety of other treatment services, including residential programs that provide housing and employment opportunities. The MBP has received funding from a variety of local, State, and Federal sources.

Another aspect of the project is its continued close cooperation with the New York City Police Department, which today provides the seven officers in unmarked cars who patrol the streets looking for public inebriates and the homeless. Public intoxication was decriminalized in New York State in 1976, largely because of the success of these rescue teams, each of which consists of a police officer and a civilian aide, said Geffner.

The team assesses the potential client's condition and drops the person off at one of the MBP programs, a general hospital, or other alcoholism program. In addition to looking for those who want to detoxify, the teams remove public inebriates from doorways and unsafe places such as intersections, take them home, prevent their harassment, and resolve disputes.

MBP's inpatient detoxification unit provides 24-hour care for acute withdrawal, and treatment of other illnesses associated with alcoholism. Patients are detoxified with medication under medical supervision. Counseling and referral services help the patient to better understand his or her condition and encourage the seeking of further rehabilitation. The average stay is 5 days.

MBP's outpatient department was opened in 1970 to supplement the detoxification facility. Psychiatric services, individual and group therapy, alcoholism education, vocational counseling and placement, and social activities are offered. Each client must visit the clinic daily for disulfiram and vitamin supplements and must attend one individual and one group counseling session weekly. Although few clients remain sober for many months without relapse, it is felt that even brief periods of sobriety are important for improving physical health.

To further enhance its continuum of care for the public inebriate, the MBP opened the West Side Social Setting Alcoholism Treatment Center in 1977. Funded by NIAAA and the New York State Department of Mental Hygiene, the 40-bed unit, which provides nonmedical detoxification, was the first of its kind in the eastern U.S. Drug-free withdrawal decreases the risk of physical addiction to other drugs and lowers costs while providing a safe, warm environment, according to MBP staff. Patients are screened before admission, and emergency medical backup services are available. Patients attend rap sessions, Alcoholics Anonymous (AA) meetings, counseling sessions, and alcohol education meetings that focus on the need for treatment. Referrals for further care are made.

Project Renewal is a unique year-long work training and job placement component started in 1970. Men live in halfway houses in a therapeutic environment while employed in public jobs. They rotate responsibilities for cleaning, cooking, and shopping, and participate in house meetings and therapeutic activities. There are five onsite counselors, and outpatient clinic staff visit the site each week.

"We contract with businesses to do street cleaning, light construction, repairs in apartments and homes, and work on parks and play lots," Geffner said. Residents can receive training and employment in landscaping, demolition, painting, carpentry, masonry, electrical repair, plumbing, and building rehabilitation.

Some of the graduates eventually become counselors, rescue aides, medical aides, clerks, custodians, and cooks for the MBP. Others seek private sector employment.

The MBP also supports two 6-month transitional residency programs. Attempts are made to include the men in school, job training, or employment.

Geffner estimates that, of those who take part in the Bowery program, "maybe 5 percent stay sober." Nevertheless, he feels the numbers are encouraging considering that many of these persons have been chronic alcoholics most of their lives.

For further information, contact Edward I. Geffner, Project Director, Manhattan Bowery Corporation, Manhattan Bowery Project, 8 East 3rd St., New York, NY 10003.

— *Nancy Johnson*

California Case Impacts Treatment

A major class action and taxpayer's case recently decided by the California Superior Court involved three public inebriate plaintiffs who collectively — in the decade prior to filing their suit (1964-1975) — had been arrested a total of 645 times and were incarcerated for a period exceeding 16 years solely for public drunkenness. In what is commonly referred to as the *Sundance Case*, after plaintiff Robert Sundance who initiated the action, the three contended that during the period 1972-1975 they entered 64 not guilty pleas at arraignment, were imprisoned 1,419 days, and never received a single trial. The court ruling ordered significant upgrading of all law enforcement procedures and detention facilities, and had the immediate effect of dramatically curtailing criminal justice involvement, since fewer public inebriates could be processed and accommodated without substantially increasing expenditures. The court further ruled that diversion of the public inebriate to treatment was significantly more cost effective than penal processing, specifically finding that $7.4 million in potential savings could have been realized by the City of Los Angeles in 1976 with full implementation of diversion.

In Rehabilitation Effort

Florida Program Instills 'Sense of Pride and Dignity'

The Comprehensive Alcoholism Rehabilitation Program (CARP) of West Palm Beach (FL) stands out among public inebriate programs in that it has collected more than $150,000 annually in donations from former clients and in donated services and supplies to help defray program costs.

"We instill in people a sense of pride and dignity and don't treat them as hopeless charity cases; we don't allow them to feed off the system," says CARP Executive Director Robert Bozzone. This is accomplished by — immediately after detoxification — telling clients what it will cost to help them reach the point where they can return as functional members of society, have a job, and maintain themselves. Clients are also told that the program is willing to invest in them if they, when they reach self-sufficiency, are willing to help the program help others. The clients depend on the program for 3 to 4 months, but once they start working, they begin to pay for their room and board as well as their care.

The program was started in 1968 by a recovering alcoholic who borrowed $300 to convert an old storefront in the downtown area and to provide room and board for public inebriates. Today, there are 13 CARP programs in 10 separate buildings.

"Our goal is to develop a comprehensive service delivery system designed to provide a continuum of care for the public inebriate," Bozzone says. "We want the same quality and quantity of services that exist for everyone else."

The program provides services for the diverse ethnic and social groups throughout Palm Beach County. Clients are referred by the police, sheriff's office, criminal justice system, family, friends, and through self-referrals, and drop-ins. In West Palm Beach, clients enter the first stage of the program — a crisis stabilization unit — where they are assessed. Some need medical detoxification; others need mental health services, in addition to alcohol and/or drug abuse treatment.

CARP's 36-bed detoxification center in West Palm Beach — staffed by medical professionals — is the largest and most comprehensive in the county, according to Bozzone. Following detoxification, patients spend 1 week in a 14-bed assessment and planning unit where a psychiatric assessment is done and alcohol and psychosocial histories are taken. A comprehensive service delivery plan is developed for each patient.

The program has several treatment options. A 6- to 8-week suburban, coed, residental program provides group, family, individual, educational, and recreational therapies. Patients attend Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings.

A 20-bed intermediate residential facility, or halfway house, emphasizes employment and vocational skills and helps reestablish clients in the community. Clients live there 1 to 3 months and continue to attend AA and NA meetings. A 10-bed extended minimal residential program, or three-quarter-way house, is run by clients who live in the facility for 1 to 3 months. An outpatient program provides individual, group, marital, or family therapy for persons not requiring residency.

Program completion usually takes 1 year to 18 months, longer than many traditional alcoholism treatment programs because these people have more difficulties, Bozzone says. 'We're working with the late, chronic public inebriate, those who have lost just about everything. We're starting with a totally dysfunctional population." However, he says, there is a 40 percent recovery rate based on 1 year of abstinence from time of discharge.

Clients who find jobs usually pay about $60 in room and board and $10 to $20 monthly on their back bill. Outpatient treatment is based on a sliding scale with a $3 per session minimum payment. "There's little resistance to paying and almost a sense of pride," Bozzone said. Although clinicians initially felt bad about asking people to pay, they changed their minds when told by the clients how important payment was to their self-respect, he said.

About $60,000 in supplies and services have been donated by program participants and graduates, and the remainder of the $1.85 million budget comes from NIAAA, State, and county funds. The halfway houses are self-supporting.

Collection of some of the client funds is aided by the program's financial department that assists clients with their affairs — pensions, benefits, and establishment of bank accounts. Very often the clients get money they never knew they could get, Bozzone said.

The program also offers some special services in Palm Beach County for other population groups — including the elderly, tuberculosis patients, migrants and farm workers, and criminals. A 17-bed domiciliary for the chronically dysfunctional elderly patient offers nursing and rehabilitation services for an extended period of time. Sixty-five percent of the patients have organic brain syndrome. "Five years ago, there was nothing for the poor, old, and brain-damaged," Bozzone said.

At the State tuberculosis hospital, half of one floor is devoted to care of alcoholics. In the past, more than 90 percent of the patients in the hospital had been alcoholic, Bozzone said, and were leaving, getting drunk, not taking their medication, and having to return to the hospital. Now the rate of recidivism has been reduced by half, he said.

In the Belle Glade area, an NIAAA grant has been used to develop treatment services on a small scale for migrant and farm workers. The project is linked to the computerized tracking system of a migrant health referral project in Texas.

Finally, a criminal justice program, in which staff assists those dealing with alcoholic persons, has been started.

CARP has a total of 145 beds, and 250 clients are seen per day. About half of the 98-person staff are recovering alcoholics and former drug addicts.

Bozzone says that the average client age has been dropping in the 8 years of the program's existence. The 45-year-old white alcoholic male has been replaced by the 25-year-old polydrug user, he said. Also, he said, the younger, more aggressive clients tend to require more confrontive therapy, conducted more often. More court-ordered referrals have necessitated tighter security, and staff has been increased to meet both these needs.

For further information, contact Robert Bozzone, Executive Director, Comprehensive Alcoholism Rehabilitation Program, P.O. Box 2507, West Palm Beach, FL 33402.

— Nancy Johnson

De Paul Center Emphasizes Individual Responsibility

"Late stage alcoholism is as treatable as early stage alcoholism if the proper treatment is used. The key difference between the two groups is recovery time," says Steve Newton, director of the De Paul Center in Portland (OR). "The person with a job may require only 3 weeks of care, but public inebriates might need 3 months to a year of treatment, even with the same commitment," he said.

The De Paul Center was started in 1977 by Newton, who had directed a detoxification center in Chicago. Upon moving to Portland, he helped transform a "dry" hotel run by the St. Vincent de Paul Society into a treatment center. Today there is a 25-member staff, 62 beds, and a client waiting list.

Patients are referred from the county detox center. They come voluntarily and for a wide variety of reasons. "Sometimes they come just to buy some time to get well enough to get drunk again," Newton said. "But we don't require motivation; our job is to provide it."

The treatment emphasizes individual responsibility. "We approach people as if they were not responsible for having the disease, but once they know they have it, they are responsible for what they do," Newton said. Moral judgments are avoided. "These are sick people getting well rather than bad people getting good," he said.

All clients attend daily AA meetings, and the De Paul Center treatment program focuses on the approaches of AA. Three weeks are devoted to exploration of three different AA-related themes — denial, surrender, and the tools of recovery. Each week focuses on a different theme, and each day looks at a different aspect.

When the client is judged ready to move on by peers and staff, he or she enters a transitional 2-week phase. Vocational assessment and job training sessions cover such topics as "How to read the want ads," "How do you fill a 30-year gap in a resume?" and "How do you deal with alcoholism in an interview?" Clients share their daily plans, attend AA and group counseling sessions, and perform a community service such as helping in the kitchen, staffing the desk, or working in the center's gift shop.

Next, the client begins to deal with "the problems of living sober in a not necessarily sober world," said Newton. The client begins to look for work and to explore individual development issues in therapy, while assuming household responsibilities and attending house meetings. A relationship with an outside AA sponsor is developed, and, occasionally, reconciliation with a family member occurs. Financial issues are explored and a place to live is found.

The average length of stay is 90 days, but many stay longer, Newton said. Patients also participate in a weekly aftercare program following discharge. About 60 percent of those tracked, who have been out of treatment for 90 days and more, have remained sober, Newton said. He also added that the average patient age is 40 years, a drop of about 5 years since the center was started.

Future plans for the De Paul Center include possibly taking over the county detoxification facility to ease the transition into treatment. Development of further residential services is also on the agenda. One company in town has donated three houses that staff hope to convert into halfway houses.

Operating funds for the center have come from NIAAA, the State Alcohol and Drug Program Office, client public assistance and food stamp monies, and individual and corporate contributions. A $1½ million development program is underway, and 10 percent of the goal already has been pledged, Newton said. The center has also received support from local AA members and leading citizens who are on the center's steering committees and board of directors.

For further information, contact Steve Newton, Director, De Paul Center, 1320 SW Washington, Portland, OR 97205.

— Nancy Johnson

San Diego Provides 'Recovery Opportunities'

In San Diego (CA), "we don't provide treatment, we provide recovery opportunities," according to Bob Reynolds, San Diego County alcoholism program administrator.

The program, run by the Volunteers of America of San Diego under contract to the county, provides limited social setting detoxification facilities. Most program money is spent on recovery services.

The program includes a reception center in the central skid row area where public inebriates, dropped off by the police, can nap, drink bouillon, or talk. They stay at least 4 hours. About 80 persons daily, or 2,200 per month, mostly men in their mid 20s to early 30s, are dropped off, he said. The center has minimal staff, mostly volunteers who have benefited from the program.

Those who choose not to go to the center, about 450 per month, are sent to jail, Reynolds said, since public inebriety has not been decriminalized in California.

For those who request detoxification, there's a 16-bed detoxification facility. The majority of public inebriates using the center choose to limit their participation and do not initially request admission to formal detox, says Reynolds, who believes that the need for detoxification has been overstated. "It's not a particularly essential service," he says. "Providing a safe environment is. We put the preponderant effort into support and recovery." Five years ago, he said, the county spent twice as much on fewer people; the program that once cost $1.2 million now costs $660,000 a year to operate, he says.

The recovery program is designed to provide a totally new experience for the alcoholic — an alcohol-free environment— and behavioral changes are expected to result. "We're not looking for insight; the changes in behavior will eventually lead to that," says Reynolds. "We are seeking to make nondrinking an acceptable lifestyle, and our long-term client outcome evaluation indicates that we are having some success.

"We provide an array of recovery support services including structured alcoholism education and discussion groups," Reynolds says. It's up to the clients, however, to participate and to give direction to the program. "We presume they can say what they need."

Those public inebriates who wish to recover enter a 20-bed, coed, residential treatment program that provides an intensive introduction to recovery. There is a 44-bed recovery home in the same building, and other recovery facilities are scattered throughout the county. The length of stay in the recovery program ranges from 90 days to a year, and a large alumni group offers peer support for those who graduate, he says.

For further information, contact Bob Reynolds, San Diego County Alcohol Program Administrator, 2870 4th Ave., San Diego, CA 92103.

— Nancy Johnson

Partnership in LA Spurs New Rehabilitation Center

In recent years, Los Angeles has confronted the problem of public inebriety head-on. In 1974 a social setting detoxification facility was opened as an alternative to jail for the public inebriate. It eventually grew to include a drop-in reception center and residential recovery services. This year, an $8 million detoxification and treatment center will open in a renovated hotel. Its staff believes the project will lower hospital and criminal justice costs while providing sanctuary for public inebriates and greater incentive for their sustained sobriety.

The social setting model is favored because, "as opposed to the criminal justice or medical model, it is cheaper and more humane, and the potential for rehabilitation is there," says Edward Eisenstadt, director of the Los Angeles Alcoholism Services Division of the Volunteers of America, which operates the program under contract to Los Angeles County.

Prior to 1974, says Eisenstadt, public inebriates were routinely jailed, where they received little treatment or rehabilitation, returning to the streets and repeating the cycle.

To deal with the problem, a pilot diversion project was started. Public inebriates referred by law enforcement officials were placed in a social setting detoxification facility. Today, it receives 1,200 police referrals per month, and five times as many referrals from agencies or from public inebriates themselves. Drop-ins stay for up to 8 hours and receive counseling, food, and a shave and shower.

A reception center, open 24 hours a day, screens persons to determine who needs detoxification services. Detoxification costs about $30 per day as opposed to somewhat higher costs to keep a public inebriate in jail, Eisenstadt said. Social setting detoxification is conducted in an 80-bed facility where patients stay an average of 2.2 days. Most clients are then transferred to one of several 90-day residential recovery facilities.

The typical client is a 41-year-old male with a 20-year history of alcohol use, he said. The 85 staff members who run the programs are mostly recovering alcoholics who have gone through extended inservice and on-the-job training.

Services provided by the program include individual and group counseling, recreational activities, nutritional training, and attention to medical problems. A residential, client-run government promotes decision-making. Within 60 to 90 days, the residents usually are self-supporting and paying for their own care, Eisenstadt said.

A manpower training program provides vocational skills, locates job opportunities for clients, and eases reentry into the community and job market. About 20 percent of those who complete the full program remain sober at least 1 year, Eisenstadt said.

The Weingart Rehabilitation Center, which will open late this year, will triple the city's ability to provide services for public inebriates. More than $8 million in public and private funds have been raised over a 2-year period for the project. "What is unique is the partnership between the private sector, the law enforcement and criminal justice systems, and health care and private philanthropy," said Eisenstadt. The center will be housed in a large skid row hotel that was donated by a private foundation.

The center will provide drop-in reception services, social setting detoxification, and recovery programs. Supportive services will include consumer education, mental health referrals, and work experience programs. Supervised low-cost emergency housing also will be available.

For further information, contact Edward Eisenstadt, Director, Volunteers of America of Los Angeles, Alcoholism Services Division, 611 East 5th St., Los Angeles, CA 90013.

— *Nancy Johnson*

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Editor: John Small
Art Editor: Julie Kurz

meetings

May 9-13. Minneapolis, MN. Another Chance: Hope and Health for Alcoholic Families. Contact Evie Silverman, ONSITE Training and Consulting, Inc., 1645 Hennepin Ave., Suite 206, Minneapolis, MN 55403.

May 10-14. Minneapolis, MN. Intervention Skill Development Workshop. Contact Jan Winsand, Johnson Institute, 10700 Olson Memorial, Hwy., Minneapolis, MN 55441-6199.

May 12-13. Houston, TX. Ninth Regional Institute of Alcohol and Drug Studies. Contact Brett Arkinson, Houston-Galveston Area Council, P.O. Box 22777, 3701 West Alabama, Houston, TX 77027.

May 13-14. Boise, ID. An Integrated Management System for Administrators in Alcoholism. Contact Kim Hilberg, National Association of Alcoholism Treatment Programs, Inc., 17861 Cartwright Rd., Irvine, CA 92714.

May 14. Milwaukee, WI. Adolescents, Alcohol, and Drug Abuse. Contact Dorothy Dow, Coordinator of Training, De Paul Rehabilitation Hospital, 4143 S. 13th St., Milwaukee, WI 53221.

May 16-21. Minneapolis, MN. Chemical Dependency and Family Recovery Workshop. Contact Betty Reynolds, Johnson Institute, 10700 Olson Memorial Hwy., Minneapolis, MN 55441-6199.

May 24-27. Peoria, IL. Third Annual Illinois Institute on Drug Abuse. Contact IDDC, 300 N. State St., Chicago, IL 60610.

May 26-28. Regina, Saskatchewan. 1982 Western Canadian Alcoholism Conference — How Tough Love Works at Home, at Work, in Your Life. Contact Conference Chairman, 2839 Victoria Ave., Regina, Saskatchewan, Canada, S4T 1K6.

June 7-11. Springfield, MO. National Symposium on Alcohol and Drug Studies. Contact Rosa Archibald, Burrell Community Mental Health Center, P.O. Box 1611 SSS, Springfield, MO 65805.

summer schools

June 20-25. Fayetteville, AR. Mid-South Summer School on Alcohol and Drug Problems — Prevention and Treatment. Contact Gwen Briscoe, Graduate School of Social Work, University of Arkansas at Little Rock, Little Rock, AR 72204.

June 21-July 2. Seattle, WA. 33rd Anual Symposium on Alcoholism. (Also, special 1-week sessions are available throughout June 21-August 13). Contact Alcohol Studies Program, Seattle University, Seattle, WA 98122.

June 22-July 13. Seattle, WA. Sexuality for Alcoholism Counselors. Contact Alcohol Studies Program, Seattle University, Seattle, WA 98122.

July 11-16. New Brunswick, NJ. Alcohol, Human Sexuality, and Personal Growth. Contact Gail Gleason Milgram, Center of Alcohol Studies, Rutgers University, New Brunswick, NJ 08903.

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IFS No. 96
June 1, 1982

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1982 Prevention Campaign To Be 'Cooperative Effort'

Drinking alcohol while pregnant may cause irreversible mental retardation in the unborn child.

Greater numbers of women are drinking now than ever before.

Alcohol-related accidents account for 60 percent of the highway fatalities among 16-24-year-olds.

These and other facts encouraged the National Institute on Alcohol Abuse and Alcoholism 2 years ago to develop a 1982 Alcohol Abuse Prevention Campaign directed at women and youth. The campaign is a cooperative effort among the Federal Government, national voluntary organizations, State governments, and local groups.

All of the materials were "showcased" in five regions throughout the country and by many of the States in cooperation with local chapters of the American Red Cross, the YWCA, Parent Teacher Associations, and Junior Leagues, governors, mayors, city councils, superintendents of schools, State automobile associations, Indian community groups, chiefs of police, parent organizations, extension agents, 4-H clubs, and local media representatives, all of whom are serving to make the campaign a success.

The campaign combines a mass media strategy with a local prevention strategy. Public service announcements have been distributed to national television networks and to local TV and radio stations, with support from State and local organizations. Posters, ads, and brochures are being distributed to newspapers and to a wide range of organizations serving women and youth.

Dr. Joyce Brothers is the honorary spokesperson for the 1982 Alcohol Abuse Prevention Campaign.

The campaign attempts to portray positive role models to women and youth so that they may develop healthy alcohol refusal skills. "It is socially acceptable to refuse alcoholic drinks," says Susan Maloney, campaign project officer, "but it's difficult to get that concept across to teenagers and women who are constantly facing social pressure to drink. Our other message," added Maloney, "is 'For baby's sake . . . and yours, the safest choice is not to drink during pregnancy!"

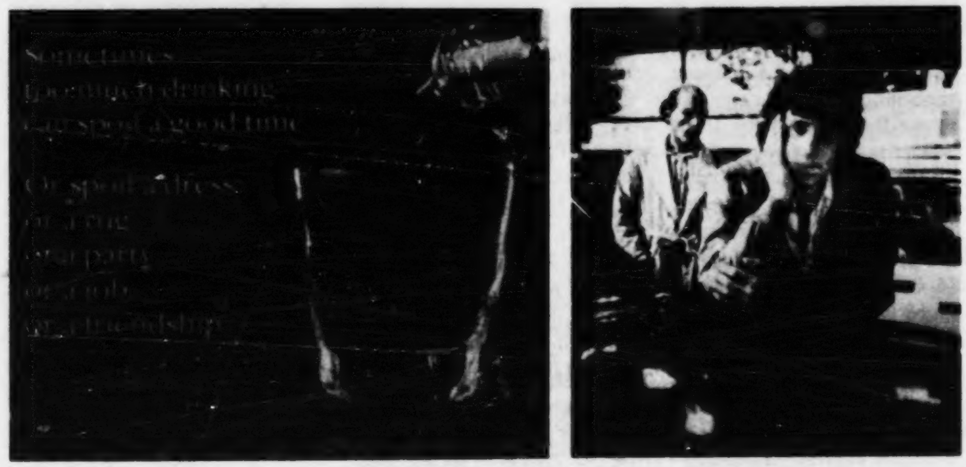
The materials are being distributed by the State Alcoholism Authorities (SAAs) and local organizations concerned about preventing alcohol problems. Interested organizers spread information about the campaign, urge broadcasters and other media outlets to use campaign materials, and sponsor prevention activities in local communities.

Innovative ideas already have been generated by local groups. One group has developed a button, "Be a Friend — Don't Let A Friend Drive Drunk." Several States have developed a year-long strategy for releasing the three phases of the campaign — fetal alcohol syndrome, women, youth — at different stages. Local campaigns, city debates, governors' proclamations, school programs, billboards, Public Broadcasting System (PBS) and cable programs, Statewide conferences, exhibits, health fairs, and a whole host of other activities already have been planned and generated by the campaign.

The campaign was showcased at the national level on April 27 in Washington, DC. High government officials, national voluntary organizations, and State and local groups kicked off the national publicity for the 1982 campaign efforts.

For further information, contact the campaign coordinator at your State Alcoholism Authority. The number usually is listed in the telephone directory under State government offices, or call (800)227-3846 and ask for the Alcohol Campaign Coordinator. (This 800 number is in service until June 30, 1982.)

—From NIAAA



Public Service Spots from the 1982 Alcohol Abuse Prevention Campaign

HE 20. 8312:

Counselors Learn To Help Violent Alcohol Abusers

Abusing Men Exploring New Directions (AMEND) is a Denver-based group that provides training and guidance to mental health and other treatment centers interested in counseling the battering — and often alcohol-abusing — client. AMEND currently provides consultation and technical support to five Colorado counties, plus several community centers, safe shelters, and counseling organizations.

According to AMEND coordinator Michael Lindsey, forcing the batterer to confront the source of his violence is the main objective of the counseling. "Most batterers are hurt individuals who have been taught to transfer that hurt to anger and then to violence," Lindsey says. "We confront the batterer with 'you are hurt, not angry, and you need to learn what it is that is hurting you.' The batterer believes it is the outside world that causes him pain — he must learn that the pain is internal."

In addition, says AMEND staffer Mary Jane McBean, 50 to 75 percent of the battering cases seen by the Denver groups have been aggravated by the presence of a drinking problem. "In these cases, we advise that clients enter treatment for the alcohol problem at the same time they enter treatment for the battering problem." Also, she says, "The treatment regimens need to be separate since these are two distinct problems. In many cases, the battering will continue long after the drinking has subsided."

Consistent in the background of battering men, according to Lindsey, is a high-stress family. Lindsey's experience indicates that the batterer is most often the product of divorce, child abuse, spouse abuse, an alcoholic parent, or an overly demanding parent — usually a domineering or disapproving father whose standards the boy could never live up to. The child's world has always been unsafe, and when he develops an intimate relationship with a nurturing partner, he is constantly fearful that she will go away. The result is the high-control, intimidating, abusive behavior that is an attempt to maintain her presence in his life, says the counselor.

In many cases, according to Lindsey, the situation has been exacerbated by a past history of bad experiences in relationships with women. Since the batterer believes he can't rely on the woman to stay with him, he constantly looks for signals of her departure. This is often manifested in irrational jealousy and paranoid fantasies concerning his partner's fidelity. Group, couples, and individual counseling can be utilized, depending on the individual and the partner's willingness to participate in the process. Sometimes, the woman just wants to get out of the relationship, Lindsey says. The counseling process usually takes a minimum of 6 months, and the longest a client has remained in treatment has been 2 years.

Most of the men don't like being violent, and the violence usually diminishes with the onset of treatment, Lindsey says. Often, the battering male must experience the loss of his partner before he will seek treatment.

"Remember," says Lindsey, "that the battering male is typically a high-control individual to whom personal power in a relationship is everything. Therapy transfers some of that power and control to the partner, which is a frightening prospect for the batterer. No matter what happens, though, the victim must never feel responsible for the violence; the batterer is always responsible for his behavior."

For further information write to Michael Lindsey or Mary Jane McBean, M.S., c/o Alternatives To Family Violence, P.O. Box 385, Commerce City, CO 80037.

—Lisa Katz

Effects of Hypertension May Be Reversible

Heavy drinking is an important but insufficiently recognized cause of high blood pressure, according to J. B. Saunders and associates of King's College Hospital in London, England.

There's good news, however, for the drinker who can be persuaded to abstain — the effect appears reversible.

The investigators studied 132 patients who had been drinking more than 80 g of alcohol (six drinks) daily for the preceding 3 months. They found that those with higher blood pressure reported a higher mean daily alcohol intake and experienced more severe withdrawal symptoms. However, in most patients, blood pressure fell to normal after detoxification and remained so in those who continued to abstain for at least a year.

"We found that there was a sustained reduction in blood pressure in response to abstinence from alcohol even in patients who had previously required antihypertensive drugs," the researchers reported in the British medical journal *Lancet* (Sept. 26, 1981; pp. 653-656).

This is important because, among heavy drinkers, conventional drug treatment for hypertension is usually unsuccessful, presumably because of the opposing effects of continued alcohol intake. The death rate from cerebrovascular disease (stroke, for example) is high among heavy drinkers and, the researchers say, is related to their higher blood pressure. The researchers estimated that high alcohol intake may be responsible for as many as 25 to 30 percent of all cases of primary hypertension.

Past studies, however, have given conflicting results regarding the relationship between alcohol and blood pressure. Some studies have suggested that those who drink moderately (less than 40 g daily) do not have higher blood pressure than abstainers; indeed some of these persons may have lower pressure.

Other studies have indicated that the risk goes up gradually as alcohol consumption climbs and, for heavy drinkers, the risk appears greatest. "Our results suggest there is a linear relationship between blood pressure and current alcohol intake from a level of 80 g per day up to the maximum regular daily intake that can be metabolized by man, approximately 400 g," Saunders and associates say.

Because the effects of heavy drinking appear reversible, the researchers concluded, early recognition of heavy drinking in hypertensive patients should be emphasized. Among hypertensive patients, the involvement of alcohol always should be suspected, the study indicates.

For further information, contact J. B. Saunders, Liver Unit, King's College Hospital, London, England.

—Nancy Johnson

Burnout Seen as Problem For Alcohol Counselors

Alcoholism counselors are at high risk for "burnout," says clinical psychologist and psychoanalyst Herbert J. Freudenberger, Ph.D., but there are specific steps that professionals can take to address the problem and improve their effectiveness.

According to Freudenberger, who has written numerous articles on the subject and trained many staffs of alcohol and drug abuse programs, burnout is a long-term process. It manifests itself in feelings of "being worn out," and can include such physical symptoms as sleeplessness, headaches, body aches, lowered resistance to illness, and chest pains. The behavioral signs may include sudden outbursts of anger or temper, feelings of helplessness or hopelessness, boredom, discouragement, cynicism, disenchantment, or resentment.

Burnout is compounded, he says, by the fact that many alcoholism counselors — especially recovering alcoholics — bring an intense personal commitment to their work. In addition, the work is often physically strenuous and emotionally demanding, and may involve long hours and low pay.

The causes of burnout, Freudenberger says, are numerous. Counselors may feel that they have little chance for advancement, or feel frustrated in not being able to make an impact on their clients, many of whom may be openly hostile. The counselor may also feel administrative pressures and other stresses that may be inherent in helping organizations.

Perhaps the most important step in addressing burnout, he says, is to recognize it as a serious problem. Freudenberger suggests peer support and rap groups since, he says, "alcohol counselors often do not have a systematic way to ventilate their feelings. Honest communication is critical in recognizing that you are not alone in your feelings."

He also suggests that counselors take a personal inventory. "Look at your daily job functions and reflect on what in your job helps to promote burnout. Do you have too many cases? Are you working alone without adequate feedback? Have you been in your setting too long? Are you feeling overwhelmed? Do you feel trapped by the routine of working with the same groups, such as drunk drivers, public inebriates, offenders in prison?" Having the knowledge of these job factors can allow a counselor to reevaluate and shift some functions and, perhaps, limit one's goals.

It is also essential that alcohol counselors establish realistic goals for themselves. "You cannot help the whole world," he says. "Some people either don't want, aren't ready for, or cannot accept your help. It's not your fault if they won't respond." For administrators, Freudenberger suggests looking closely at the management style to make sure that it allows feedback and permits flexibility and sensitivity.

Finally, he says, counselors should make sure thay have a life outside of work and take special care not to lose their sense of humor. "If you are married, you should share some of the tensions of your job with your spouse," he says. "If not, speaking with a trusted friend or colleague is important. Their caring, support, and trust can help a great deal. And your sense of humor will stand you in good stead many times during a trying day and can go a long way toward helping diminish burnout."

For further information, contact Herbert J. Freudenberger, Ph.D., 18 East 87th St., New York, NY 10028.

— John Small

Layoffs, Alcohol Consumption Rate Studied

In small communities that rely on a single industry for their economic well-being, employee layoffs are accompanied by increased alcohol consumption, according to a study reported by Edward Weeks, Ph. D., assistant professor in the School of Community Services and Public Affairs at the University of Oregon.

Weeks, who spoke at a recent National Institute on Alcohol Abuse and Alcoholism (NIAAA) epidemiology seminar, studied several small Oregon towns and found overall community drinking increased significantly when employees were laid off from their jobs in wood products mills. The mills were the major source of employment within the communities. "Other healthier and more diversified communities throughout the country may be experiencing similar effects," Weeks said. "Community economic distress has become a problem of national importance. Plant relocations, business failures, and extended layoffs have become epidemic not only in economically distressed regions but also in regions that are economically healthy," he said.

According to Weeks, layoffs may create new behavior patterns that promote drinking. For example, he said, because the worker is idle, there is more available free time for drinking and socializing. The worker may drink more in the home or frequent taverns with friends more often.

In his study, Weeks hypothesized that economic change causes stress and stress induces drinking. Previous unemployment studies have supported the observation that economic change causes stress and indicated that loss of work disrupts family and social relationships and causes anxiety and depression. Sample surveys have documented decreased self-esteem and increased feelings of powerlessness and helplessness among unemployed workers. Recently, one study indicated that changes in the manufacturing work force in New York State resulted in increased State hospital admissions. Another study found that economic change is strongly related to the occurrence of stressful life events and also to mood; that is, during an economic decline, the incidence of depression is much higher. "So, from a diverse range of research, there is a lot of evidence to say the economy is a generator of stress," Weeks said.

The second part of his hypothesis — that stress induces increased drinking — while generally accepted as true, has received less empirical support. Some research indicates that people who feel drinking will relieve stress are motivated to drink, while those who don't think it will help, don't drink. One field survey found that personal life or job stress is most likely to result in increased and more problem-prone alcohol consumption. Another showed that hardships generate anxiety, and some people tend to use alcohol as a temporary escape from unpleasant stress.

The current study provides less biased data, however, because alcohol consumption is measured strictly on the basis of sales, and in Oregon all distilled spirits are sold through liquor stores that must report their sales. The small Oregon towns are relatively isolated. Thus, the effects of a mill shutdown are readily apparent and unlikely to be affected by outside factors.

For further information, contact Edward Weeks, Ph.D., Assistant Professor, School of Community Services and Public Affairs, University of Oregon, Eugene, OR 97403.

— Nancy Johnson

The McKenzie Area Prevention Project

Structure

Community Organizing	Family Management Coordination	Youth Alternatives
Block Clubs	Parenting Programs	Drama Groups
Community Associations	Youth, Parent Workshops	Leadership Programs
Grant Writing	Referrals to Treatment	MAPP Institute
Prevention Education		Recreational Activities

A Three-Tiered Approach to Prevention

"Our goal is to provide families with as much information as possible so that parents can help their children resist alcohol and drug abuse. Since the family is the greatest unit of nurturing, that's where we decided to target our prevention efforts."

This family-oriented approach to prevention underlies all of the activities of the McKenzie Area Prevention Project (MAPP), a program designed to serve the needs of 67,000 residents of a predominantly black urban neighborhood in Detroit. The program, now in its third year of operation, is funded by the Michigan Office of Substance Abuse Services (OSAS) and last year won a Minority Program Award from the National Council on Alcoholism.

"Many families perpetuate certain myths about drinking — that it is a rite of passage, that it is the way to relax — and we wanted to teach people that there are other ways of growing up and moving into adulthood," comments program director Annette Brodie, CAC. "By teaching the family, we lessen the chances of the same myths getting passed on from generation to generation."

Funded at $185,000 per year, MAPP employs a program director, a community organization specialist, a family management coordinator, a youth alternatives coordinator, and a secretary. Extensive volunteer help includes student interns (3 at present) and 13 community liaisons. Welfare recipients also work in the program, coordinated through the local workfare program.

Although the prevention activities are aimed at the entire community, their primary target is those aged 8 to 18. "Prevention is a tool for equipping young people to resist alcohol and drug abuse," says Brodie, "and we are the catalyst for doing that. However, by working with the community and the individual families, we give the process more organization and make it a group struggle rather than an individual one. We try to make peer pressure work against alcohol abuse instead of for it."

The McKenzie area, which surrounds Detroit's McKenzie High School, was targeted by prevention planners because it was seen as "high risk," Brodie says. There was a high rate of drug- and alcohol-related deaths, the cirrhosis rate was high, and there was a high number of traffic fatalities. However, in the mid 1970s, there was also a strong desire on the part of area residents to do something, and this spawned a peer counseling program in the high school to help youngsters address decisions about drug use and drinking.

The neighborhood was also chosen, according to Mark Steinberg, chief of the prevention section at Michigan's OSAS, "because we wanted a community that was a distinct neighborhood, one that had not been heavily targeted by human service agencies, and one where we felt prevention services had a strong chance of working. We looked at a variety of indicators before selecting the McKenzie area."

He adds, "One of the main issues we faced in planning the program was the attitude among some policy makers in the area that the main substance abuse problem among area residents was hard drugs, primarily opiates. Most of our data, however, indicated it was alcohol. After looking at indicators like the number of auto accidents and homicides in the Detroit area, we came away convinced that alcohol was the number one problem."

Eventually, area residents began to get involved and, with the help of the Detroit Health Department, drew up a proposal for a prevention project to serve their "uniquely urban needs." In 1979, the State of Michigan funded a grant, which was originally administered by the City of Detroit. When the city shifted its role to that of program coordinator in 1980, the project was shifted to a community mental health agency and, later, to NCA of Greater Detroit. "The organizational changes are the only real problem the program has had," Steinberg said. "That has made it difficult at times. It's been a matter of finding the right home for it."

In the past year, the program has developed a "three-tiered approach" to urban community involvement in prevention that includes youth alternatives, family management coordination, and community organization. The youth alternatives aspect, Brodie says, is perhaps the most important since it teaches young adults that there are ways to resist substance abuse by developing alternative activities. "Our goal is to provide young people with skills for competing in today's society and give them positive role models," Brodie says, adding that this involves a carefully planned series of daily and annual activities.

First, using their community liaisons and other volunteers, MAPP staff fan out into the community and run "rap groups." These focus on improving diet; developing life skills, employment skills, and leisure time activities; and learning to understand the harmful aspects of alcohol and drug abuse.

MAPP also sponsors drama groups in which McKenzie high school students develop skits and tape them for community use. In addition, MAPP runs leadership programs that teach young people how organizations run, what meetings are for, how *Robert's Rules of Order* are used, and other skills. "We don't want youngsters going into society without these basic tools," Brodie says.

Finally, MAPP runs two activities that move the program

(continued on page 5)

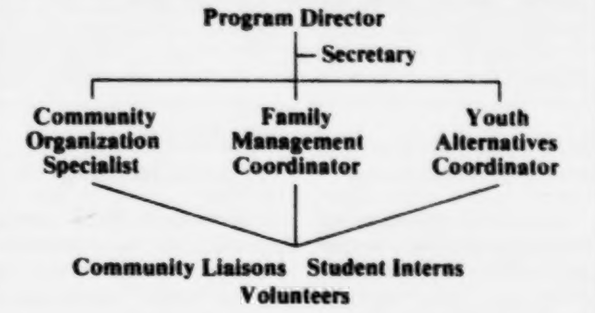
(continued from page 4)

outside the neighborhood. In the summer, MAPP sponsors a free day camp for children ages 8 to 12 in a nearby camp setting. The participants arrange for their own daily transportation. The youngsters have discussion groups, see films (such as "To Use or Not to Use"), and discuss values and family life. Also in the summer, the MAPP Institute brings together youths, parents, and staff for a "week of intensive life skills and substance abuse workshops," held last year at the Franklin-Wright Settlement Camp in Lake Orion (MI). Described by Brodie as "the cornerstone of the entire project," the MAPP Institute offers program staff a chance to turn many of the activities over to parents who participate voluntarily and function as group leaders and facilitators. During the week, the parents lead workshops on substance abuse, job skills, family life, communication skills, and coping. An average MAPP Institute involves 85 young adults and 15 parents, plus MAPP staff. However, according to Brodie, "It would not function without the parents; they're the key. Plus, the rural setting helps everyone get away from the city and look at things in a fresh perspective." The program underwrites food and lodging expenses for the participants.

At a Glance

Name: McKenzie Area Prevention Project
Location: Urban (Detroit); 10 sq. mi. area
Funding: Michigan Office of Substance Abuse Services (State)
Use of Volunteers: Students, Community Leaders, Community Liaisons, Interested Citizens
Outreach: Monthly Newsletter, MAPP Day, Health Fair, Alcohol Awareness Month; also liaisons with public and private agencies, including community mental health centers, the YMCA and YWCA, schools, businesses, libraries, and neighborhood associations.

Staffing


Program Director
Secretary
Community Organization Specialist
Family Management Coordinator
Youth Alternatives Coordinator
Community Liaisons
Student Interns
Volunteers

The second tier of the MAPP project is a series of family management and parenting programs designed to "reinforce and strengthen the family unit, and provide parents and youth with skills to communicate effectively about stress, self-esteem, and the ramifications of alcohol and drug abuse." Specific programs include parent training workshops — in which parents are trained so that they can lead future workshops themselves — and parent support groups, which are designed to teach parents to see themselves as resources capable of developing alternative recreational activities for the family. According to Brodie, these might include ice skating, roller skating, or skiing — "anything that gives the family a group activity and, at the same time, shows children and teenagers that there are alternative ways to relax and cope with stress."

Although MAPP's primary role is to set up and coordinate these parenting programs, most staff time is devoted to recruiting interested parents and training them to put on future workshops themselves. In addition, the MAPP groups often result in referrals to Alcoholics Anonymous, Al-Anon, and Alateen. According to Brodie, those with obvious alcohol or drug problems are referred to appropriate treatment agencies.

MAPP's third component is community organization, in which staff help people start block clubs and community organizations and pursue available grant money for fighting alcohol and drug abuse. During these neighborhood meetings, Brodie says, residents learn about the problems that affect them directly, define those problems and the resources available for addressing them, and determine the role that organizations — such as government agencies, churches, and community associations — should have in the process. These meetings also serve to identify individuals — such as ministers or teachers — who work in the community and may be interested in getting actively involved in prevention.

"These community meetings were the key to getting the program started and they are the key to its success," Brodie says. "They are our way of addressing community concerns, drawing up strategies, and carrying them out. They take advantage of the community's desire to do something about the various problems."

In addition to its three main areas of concern, MAPP also has developed layoff workshops and publications such as "The Layoff Survival Kit" to aid the unemployed, and has helped draw up the first alcohol and drug abuse curriculum for middle school teachers in the Detroit public schools. MAPP staff, volunteers, and parents also visit health classes in the schools and discuss prevention.

MAPP's outreach activities include a monthly newsletter, "MAPP Community Prevention Highlights" (circulation 5,000); MAPP Day, an annual community festival with special activities for children, a battle of the bands, awards, and trophies; an annual Health-O-Rama health fair; a substance abuse awareness month in May; and an alcohol awareness month in the fall.

MAPP has also established liaison with public and private agencies in Detroit, including the United Auto Workers, the Michigan Employment Security Commission, Operation HOPE (a community mental health center), the Urban League, the YMCA and YWCA, New Detroit, Inc. (an urban coalition), the Detroit public school system, and the Detroit and Wayne County library systems.

For further information, contact Annette Brodie, Program Director, McKenzie Area Prevention Project, National Council on Alcoholism — Greater Detroit Area, 500 Kales Building, 76 West Adams, Detroit, MI 48226; or Mark Steinberg, Chief, Prevention Services, Office of Substance Abuse Services, 3500 North Logan, P.O. Box 30035, Lansing, MI 48909.

—John Small

alcohol digest

Alcohol Digest is a collection of items of interest to the alcohol field.

Wisconsin Revises Drunk Driving Laws

The State of Wisconsin has made major revisions in its operating (driving) while intoxicated (OWI) laws. Under legislation that became effective January 1, 1982, anyone convicted of OWI will be required to pay a $150 surcharge on top of any other penalties or fines.

Under legislation that became effective May 1, 1982:

- Anyone convicted of a first OWI offense will be subject to a $150 to $300 fine and a 3- to 6-month license suspension.
- Anyone convicted of a second offense (within 5 years) will be subject to a $300 to $1,000 fine, a 6-month to 1-year license revocation, and 5 days to 6 months in jail.
- Anyone convicted of a third or subsequent offense will be subject to a $600 to $2,000 fine, a 1- to 2-year license revocation, and 30 days to 1 year in jail.
- Anyone convicted of OWI will also be required to have an alcohol/drug problem assessment at a State-approved, county-run agency. The agency will then prepare a driver safety plan for each driver and submit the plan to the State Department of Transportation. That plan may call for group therapy, inpatient or outpatient treatment, or alcohol education. If the driver does not comply with the plan, his or her driving privileges can be suspended indefinitely.

For further information, contact Robert H. Tribbey, Driver Improvement Program Manager, Division of Motor Vehicles, State of Wisconsin Department of Transportation, P.O. Box 7917, Madison, WI 53707.

Disabled Alcoholics Topic of Meeting

As a part of its activities focusing on the International Year of Disabled Persons, the Social Security Administration, through its employee Alcoholism and Drug Abuse program, has been highlighting the special issues involved for its employees who may be multidisabled alcoholics. A recent meeting addressed the needs of blind or visually impaired alcoholics.

For further information, contact Barbara P. LeCroy, Chief, Personnel Counseling Branch, Social Security Administration, 3119 Annex, 6401 Security Blvd., Baltimore, MD 21235.

Journal Seeking Alcohol Research

Contemporary Drug Problems — A Law Quarterly is seeking papers and articles containing empirical and theoretical research pertaining to legal and criminal aspects of alcohol and other drug abuse. For further information, contact James C. Weissman, Editor in Chief, *Contemporary Drug Problems,* 516 Eastbrook Dr., Charlottesville, VA 22901.

Newspaper Column Focuses on Alcohol

"The Spirits Scene," a weekly newspaper column on the use and abuse of alcohol and other drugs, is designed to enable the general public to raise questions about alcohol abuse and alcoholism. Written by William van Almen, Ph.D., director of the Frederick (MD) Counseling Clinic, the column responds to questions that are sent in by readers of subscribing newspapers. In its first 6 months, the column has responded to inquiries about the disease concept, social drinking, alcohol and pregnancy, alcohol and teenagers, and the stigma of alcoholism.

For further information, contact William van Almen, Ph.D., Frederick Counseling Clinic, 149 West Patrick St., Frederick, MD 21701.

New AA Pamphlet Focuses on EAPs

A new leaflet, *Alcoholics Anonymous (AA) and Occupational Alcoholism Programs,* offers information on ways that AA can help companies, unions, and governmental agencies that are setting up programs for alcoholic employees. While AA does not establish such programs, its members can assist by meeting informally with management, personnel directors, union leaders, and employees, by discussing ways that AA can cooperate with them, and by describing the AA program.

For further information, or for a copy of the pamphlet, contact the General Service Office, Box 459, Grand Central Station, New York, NY 10163.

Information Available For Impaired Lawyers

In an effort to assist State and local bar associations in dealing with the problem of impairment among their members, the American Bar Association has developed an information package that presents an overview of current activity in the area of alcoholism and drug abuse problems among lawyers and judges. The package includes descriptions of individual programs at the State and local level, plus information on policy statements, program manuals, handbooks, brochures, speeches, articles and news editorials, and other national organizations concerned about the problem.

For further information, contact the Division of Bar Services, American Bar Association, 77 South Wacker Dr., Sixth Floor, Chicago, IL 60606.

Alcohol Education Information Sought

Craig House, a private psychiatric hospital with a 4-week inpatient alcoholism treatment program, is revising its alcohol education program for patients. Project staff are interested in exchanging information on such programs with other treatment facilities. Of special interest are guidelines for alcohol education programs, effective formats, and evaluation materials. Contact James Morris, M.D., Craig House, P.O. Box 87, Beacon, NY 12508.

Alcohol on Campus Subject of Report

The Rutgers University Committee on the Use of Alcohol has compiled a detailed report on the issues surrounding alcohol use and abuse in a university setting. The report examines alcohol as it relates to university life, including drinking by students and faculty, alcohol's effect on learning, and the campus "pubs." The report provides a list of recommendations, including a proposal for education and training programs and an assistance program for students with alcohol-related problems. The report is available for $2.60.

For further information, or for a copy of the report, contact Peggy Clarke, Director of Health Education, 301 Van Nest Hall, Rutgers University, New Brunswick, NJ 08903.

meetings

JUNE

June 2-5. River Forest, IL. Issues, Insights, and Concepts: Current Trends and Research in the Field of Alcoholism. Contact Stella Nicholson, C.A.C., Central States Institute of Addiction, Continuing Education Program on Addiction, 120 West Huron St., Chicago, IL 60610.

June 6-11. Richmond, VA. Treatment of the Alcoholic and Drug Addict With Significant Others (Family). Contact Ethel Bass, Alcohol and Drug Education/Rehabilitation Program, Department of Rehabilitation Counseling, 812 West Franklin St., Richmond, VA 23284.

June 7-8. St. Louis, MO. Marketing Employee Assistance Programs. Contact Jan Burggrabe, Coordinator of Health Programs, University College, Washington University, St. Louis, MO 63130.

June 7-10. Moorhead, MN. Counseling the Family of the Chemically Dependent. Contact Debby Thornton, C.D. School Secretary, Department of Social Work, Moorhead State University, Moorhead, MN 56560.

June 7-11. Springfield, MO. National Symposium on Alcohol and Drug Studies. Contact Phyllis Rotrock, Support Coordinator, Burrell Community Mental Health Center, P.O. Box 1611 SSS, Springfield, MO 65805.

June 8-11. Byfield, MA. North Conway Institute 28th annual Assembly on Substance Abuse: Tools for Action. Contact Helen W. Packard, NCI, 14 Beacon St., Boston, MA 02108.

June 14-16. Ithaca, NY. Employee Assistance Programs for the Problem Employee. Contact New York State School of Industrial and Labor Relations, Cornell University, P.O. Box 1000, Ithaca, NY 14833.

June 27-July 1. Minneapolis, MN. Family Reconstruction Workshop. Contact Evie Silverman, ONSITE Training and Consulting, Inc., 1645 Hennepin Ave., Suite 206, Minneapolis, MN 55403.

June 29-29. Minneapolis, MN. Ericksonian Approaches to Treating Resistant Clients. Contact Bev Ringsak, Department of Conferences, 335 Nolte Center, University of Minnesota, 315 Pillsbury Dr. SE., Minneapolis, MN 55455.

summer schools

June 10-12. Milwaukee, WI. Fourth Annual Summer Institute: Family Recovery. Contact Dorothy Dow, Coordinator of Training, De Paul Rehabilitation Hospital, 4143 South 13th St., Milwaukee, WI 53221.

June 13-18. Colorado Springs, CO. Eighth Annual Colorado Summer School of Alcohol Studies. Contact Don Dehon, Executive Director, Alcoholism Council of Colorado, 2525 West Alameda Ave., Suite 219, Denver, CO 80219.

June 13-18. Richmond, VA. Institute of Alcoholism and Drug Abuse. Contact Ethel Bass, Alcohol and Drug Education/Rehabilitation Program, Department of Rehabilitation Counseling, 812 West Franklin St., Richmond, VA 23284.

June 20-25. Salt Lake City, UT. 31st Annual Session of the University of Utah School on Alcoholism and Other Drug Dependencies. Contact James Swenson, M.D., Program Coordinator, University of Utah School on Alcoholism and Other Drug Dependencies, P.O. Box 2604, Salt Lake City, UT 84110.

June 20-24. Warrensburg, MO. Fourth Annual Missouri Summer Prevention Institute. Contact the Missouri Prevention Network, 1005 Cherry St., Suite 204, Columbia, MO 65201.

June 21-25. Berkeley, CA. 12th Annual Summer School on Alcohol and Other Drugs: Survey of Alcohol and Other Drug Problems. Contact Alcohol Summer School, Pacific School of Religion, 1798 Scenic Ave., Berkeley, CA 94709.

NIAAA Magazine Focuses on Self-Help Groups

Alcohol
World
SELF-HELP
GROUPS

The self-help movement began in the alcoholism field with the establishment of Alcoholics Anonymous, and has proved extremely successful in sustaining the recovery process. Today, the AA philosophy is the basis for self-help groups dealing with all sorts of problems and issues — from overeating to child abuse.

The summer issue of the National Institute on Alcohol Abuse and Alcoholism magazine *Alcohol Health and Research World* examines ways in which alcoholism treatment programs and counselors can increase their effectiveness by working with self-help groups.

The magazine also offers insight into parent action groups — parents who are banding together in communities throughout the Nation to prevent young people from becoming involved with alcohol and other drug problems. While the early focus of most such groups was on banning the sale of drug paraphernalia, attention is increasingly turning to the prevention of alcohol problems. Ways alcohol-oriented prevention programs can work with such groups are explored in an article featuring interviews with leaders in the parents movement.

In addition to the special focus section on self-help groups, the summer issue of *Alcohol Health and Research World* excerpts important findings from an NIAAA-funded study of health insurance legislation in the States. Articles report on the impact mandated or required health insurance coverage for alcoholism treatment has had on treatment programs; important considerations in the development and passage of legislation also are discussed, as are efforts of health insurers to provide coverage independent of legislated requirements.

Each issue of *Alcohol Health and Research World* brings readers a broad range of articles written by and for those working in alcoholism treatment, prevention, and related areas. It has become must reading for thousands — offering timely and relevant "how-to" information, state-of-the-art reviews, and reports on new research and clinical findings.

For an annual subscription, send a check, money order, or charge card authorization for VISA or Mastercard (card number and expiration date) for $8.50, $10.65 if your address is foreign, and mail to: Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

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Editor: John Small
Art Editor: Julie Kurz

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From the National Clearinghouse for Alcohol Information of the National Institute on Alcohol Abuse and Alcoholism

Active Client Participation Goal of Chicago Program

"Our overall purpose is to help people take control of their lives," says Father Curtis A. Waltemade, president and executive director of the Cathedral Shelter of Chicago (CSC).

Alcoholism treatment is one component of the services offered by this private, nonprofit center that serves a diverse clientele in Chicago and five surrounding counties. More than 70 percent of its operating expenses are provided through private donations; the CSC receives no direct Federal funding.

Begun in 1919 as a social service agency of the Episcopal Church to provide food, shelter, clothing, and emergency aid for Chicago's homeless and needy, CSC has evolved into a vast community resource. According to Father Waltemade, CSC offers a wide range of services in a manner that encourages self-help and constructive actions in stressful situations. Services, available to anyone, still include emergency services as well as alcoholism treatment. Alcoholism components include Higgins House, a residential social treatment center for recovering male alcoholics, and a three-quarter-way house residential program for recovering alcoholics reentering the community.

Higgins House was established in 1958, after it became apparent that many clients receiving emergency services were having problems with alcohol. According to Waltemade, Higgins House reflects CSC's holistic approach to problem solving. "We know that when a person stops drinking, the problems that stimulated the drinking may continue. So we believe that it is critical that the client participate in a program that will go further than merely treating the symptom — drinking — and get to the root of the problem."

Higgins House encourages small group interaction in a family-like, homestyle atmosphere. Residents living in the 12 semiprivate rooms spend at least 16 hours per week participating in group therapy, individual counseling, educational and nutrition meetings, and house meetings. During their stay, each resident must attend at least four Alcoholics Anonymous (AA) meetings per week — two at CSC and two in the community. Many attend up to seven meetings per week. Each resident pays a minimum of $250 per month, based on his ability to pay. They are required to find employment in the first 3 weeks of their stay. This is a central part of CSC's philosophy of self-help and facilitates the resident's transition to an alcohol-free lifestyle. If the resident is still unemployed in the third week, a CSC vocational guidance counselor works with the resident, using confidence-building exercises, such as role playing for job interviews. Further, the counselor does much of the initial "legwork," such as locating prospective employers, talking to them about the program and its objectives, and describing the resident.

The residential program of Higgins House is of 6- to 9-month duration. The three-quarter-way house is available to some of the residents to help bridge the gap between structured and independent living. Here, residents have individual apartments and a resident manager/counselor helps them tackle the problems inherent in transition. The counselor provides support to ensure that the resident attends at least one counseling session, one group meeting, and one AA meeting per week. Residents work by day and attend the sessions by night, an arrangement designed to reflect the normal lifestyle. An aftercare program, which includes a minimum 1-year followup and active AA participation, provides continuing support for the resident reentering society.

CSC's involvement with the client/resident may be as long as 4½ to 5 years. Waltemade says that approximately 75 percent of the residents complete the program. Of those, he says, a substantial majority (50 to 60 percent) remain sober up to 5 years or longer. He attributes CSC's success rate to three factors: the length of time spent with each client during treatment; CSC's long-term involvement with the client; and the association with AA, especially in the aftercare process.

In 1981, CSC used direct mail solicitation, community fund drives, media campaigns, and professional fund raisers to raise more than $800,000 for capital purposes. Donations, gifts, and grants from private individuals, groups, and foundations are the source of 70 percent of the total annual operating budget of $1.25 million. CSC also receives funds from the Illinois Department of Mental Health (14 percent), the United Way (13 percent), and Episcopal Charities of Chicago (3 percent).

Over the past year, CSC has developed a speakers' bureau and an audiovisual presentation entitled "You Don't Have To Touch A Drop" to help build up community support. Also, CSC staff have participated in television and radio talk shows and various news programs in the Chicago area.

CSC has a staff of 34, including alcoholism and counseling professionals. It is supplemented by students on field work/internships from university schools of social work, nursing, seminaries, and other graduate institutions. A core of volunteer workers is presently being developed.

CSC plans to expand its residential facilities to include women who are now served only on an outpatient basis. The Gibson Center, slated to open in 1982, will include a 40-bed center for recovering male alcoholics, and a 20-bed center for recovering women alcoholics, including those with children; three emergency apartments for families; a multipurpose room; an AA meeting room; a reading room/day shelter for nonresidents; and dining room and kitchen facilities to provide up to 250 meals per day.

For more information, contact Rev. Curtis A. Waltemade, President/Executive Director, Cathedral Shelter of Chicago, 207 South Ashland, Chicago, IL 60607.

— Millree Williams

Coming In IFS No. 98: A Special Report On The National Council on Alcoholism Forum

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • PUBLIC HEALTH SERVICE • ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

HE 20.8312:

Alcohol, Traffic Safety Focus of Detroit Meeting

More than 500 representatives of the alcohol and traffic safety fields attended a recent National Conference on Occupant Protection and Alcohol Countermeasures in Detroit to seek solutions to what one speaker called the two great highway safety problems facing the Nation — drunk driving and occupant protection.

The conference included 2½ days of presentations, workshops, and discussions on ways the U.S. can reduce injury and death on its highways. Attendees heard from representatives of the National Safety Council and other private groups; universities; Federal, State, and local governments; and alcohol treatment, prevention, and education programs as well as scores of private citizens who have become involved in these issues in their local communities.

The conference began with a speech by Vincent L. Tofany, president of the National Safety Council who told participants that "there is no one group that has the ability to solve these problems — not the Federal or State Government and not the private sector by itself." The key, he said, is a massive public education effort by all groups to inform the public that these problems are not only serious but solvable. According to Tofany, only about 10 percent of all drivers use their seat belts, and he estimated that seat belt use could save 12,000 lives per year. He also cited research showing that one-half of all highway deaths involve alcohol and that such accidents are responsible for approximately 26,000 deaths per year, or roughly 70 deaths per day. He estimated that the odds of a drunk driver being stopped by police are only about 1 in 2,000.

Following the keynote address, separate concurrent sessions on alcohol and occupant safety topics were offered. Presentations and workshops dealing with alcohol topics ranged from a discussion of prevention and education issues to descriptions of specific countermeasures that State and local governments are using to combat drunk driving.

Chuck Livingston, administrator of Traffic Safety Programs at the National Highway Traffic Safety Administration (NHTSA), said research has shown that more than 650,000 persons are injured each year by drunk drivers and that economic losses amount to more than $24 billion. He said DOT statistics show that 1 out of every 10 drivers on Friday and Saturday night is legally intoxicated and the pervasive feeling among drivers who drink is that the odds on getting caught are slim, the odds on getting convicted are even slimmer, and even convictions will bring only slight penalties. The problem is compounded, he said, because local court systems are "swamped" with drunk driving cases and have been unable to develop any coordinated policy on how to handle them.

The Nation's police forces, he said, face an even more complex set of problems. First, he said, many police officers are reluctant to arrest potential drunk drivers because of the lengthy amount of time (about 4 hours) it takes to book and process each drunk driving arrest; court appearances often place additional demands on officers' time. Many police chiefs are hesitant to make drunk driving a priority in their community, especially if there is no citizen pressure to do so, and plea bargaining in many areas causes the drunk driving charge to be reduced or eliminated, he said. The courts are often reluctant to convict drunk drivers, especially when judges feel the penalties are too harsh; some communities that have enacted legislation requiring mandatory jail terms have found that judges are even more reluctant to convict the drunk driver, he reported.

Community Involvement

Livingston outlined approaches to community involvement that have been used at the local level. Under the general deterrent approach, communities have made drunk driving a priority and have mounted all-out efforts to arrest drunk drivers. This approach also involves extensive public awareness campaigns to inform motorists that increased enforcement efforts are coming.

Some communities have enacted requirements that convicted offenders (through their fines and fees) pay for the services required to respond to their problem — such as alcohol and driving education sessions and treatment. In many areas, citizens work closely with local officials, police, judges, and treatment professionals to draw up comprehensive solutions to the problem in their community. In some cases, a long-term prevention approach has evolved, with the goal of changing societal attitudes toward the drunk driver. This often involves educational programs in the schools and in the community.

Local and State task forces on drunk driving, he said, have been highly effective tools in bringing together citizens, policy makers, and court officials to address drunk driving issues. According to Livingston, in the past year and a half, 15 States and numerous communities and municipalities have set up such task forces. He noted that it is especially important that one person within the local or State government be responsible for taking a leadership role and providing the necessary followthrough for task force activities.

He commended the involvement of citizen groups like Mothers Against Drunk Driving (MADD) and Remove Intoxicated Drivers (RID) for generating citizen interest in issues related to drinking and driving. "These groups serve to make drivers more aware," he said, "and help prevent the burnout of professionals who are most involved in the problem."

Programs Described

Clayton Hall, head of an alcohol task force at NHTSA, presented preliminary results from several demonstration projects that DOT has funded to test the effectiveness of alcohol countermeasures in reducing drunk driving. In a project that began in Sacramento (CA) in 1976, Hall said, first offenders were referred to four sessions (10 hours total) of alcohol education. Preliminary data have shown a 22 percent drop in the number of rearrests compared with a control group. Another group in the Sacramento project was sent to long-term alcohol treatment (biweekly sessions for 1 year), and the results were "quite significant," Hall said. Compared with the group that received only the educational sessions, this group showed an

(continued on page 3)

(continued from page 2)

additional 39 percent drop in rearrest rate.

A demonstration project in Stockton (CA) (1976-1978) combined increased law enforcement with a public awareness campaign. After extensive efforts to make citizens aware of the problem, local governments trained and deployed 10 one-man units on Friday and Saturday nights to patrol certain parts of the city. According to Hall, preliminary results showed that arrests in the patrolled areas increased tenfold over the same period a year before. Also, nighttime accidents were down, as were the blood alcohol levels of those arrested.

Stockton residents periodically were surveyed to see if they had heard of the local task force's efforts. At the start, only 29 percent said yes. The number rose to 56 percent after 6 months, 66 percent after 1 year, and 70 percent after 3 years. Final data will soon be available on these demonstration projects.

Bruce Madsen, managing director of the Traffic Improvement Association (TIA), a private, nonprofit traffic safety group of Oakland County (MI), described an awareness and increased enforcement program in the 900 square mile county (population 1 million) north of Detroit.

TIA began by determining the locations and time of day and week of the highest number of alcohol-related traffic accidents in Oakland County. Once the top 10 locations were determined, patrols began from 11 p.m. until 4 a.m., Wednesday through Saturday nights. The project utilized sheriff's deputies, and State and local police officers who had been specially trained at Michigan State University and special cars equipped with breathalyzers, so that the time of booking arrestees was cut to about 45 minutes. The public awareness component involved press releases, editorials on local television and radio stations, billboards, public service announcements, a speakers' bureau, and other materials.

According to Madsen, an analysis of the project is now being conducted at the University of Michigan. However, preliminary data from the first 18 months have shown that drunk driving arrests increased 30 percent, alcohol-related traffic accidents were down 21 percent, and alcohol as a factor in traffic accidents dropped from 51 to 40 percent.

Donald Savage, executive director of the New York Senate Special Task Force on Drunk Driving emphasized that public awareness and education are essential to the success of countermeasure efforts. No matter how the law reads, "if people don't feel they will be penalized, they won't take our efforts seriously," he said. He described a Special Traffic Options Program (STOP-DWI) in New York that permits counties to use fine revenues from drunk drivers to pay for enforcement, adjudication, education, rehabilitation, and other related activities at the county level.

Funding

Several other speakers discussed ways that local governments can fund efforts aimed at reducing drunk driving. According to Jim McNight, Ph.D., president of the National Public Service Research Institute, in Alexandria, VA, the most popular ways have been fees, fines, assessments, and dedicated taxes. A fee, he said, is usually $25 to $100 and is "money charged for a service provided; that is, payment directly from the convicted individual to the educator or treatment professional." A fine is money assessed as punishment and collected directly by the court. It is usually $100 to $500 for the first offense and more for the second offense. An assessment is a cost levied by the court that is usually earmarked for a drunk driving program. A dedicated tax is a tax collected specifically for the support of programs, in this case drunk driving programs, and is collected from potential users (for instance, in alcohol or gasoline taxes). It is, according to McNight, the largest potential funding source, but requires legislation.

Forst Lowery, coordinator of the alcohol program in the State of Minnesota, described that State's proposed "nickel a drink" program in which, at the wholesale level, a tax of 5 cents would be levied on each ounce of distilled spirits, 12 ounces of beer, and 4 ounces of wine. It would be a dedicated alcohol tax, used to reimburse State agencies that work on the arrest, prosecution, assessment, and treatment of drunk drivers.

Future Directions

At a session on Revitalizing State and Local Drunk Driving Programs, several proposed approaches to legislation at the Federal and State levels were discussed. Tom Seery, director of the interagency support staff for the task force in the State of New York, called for a multifaceted approach to solve the problem. He urged an enforcement campaign, a public information campaign, efforts to increase the safety of vehicles and roadways, increased efforts to rehabilitate drunk drivers, and continuing evaluations designed to reduce drunk driving.

Bill Bronrott, press secretary for Representative Michael Barnes (D., MD), and Jerry Cox, legislative assistant to Senator John Danforth (R., MO) then discussed various approaches that proposed Federal legislation could take in encouraging States to implement comprehensive approaches to the problem. No final approach has been agreed on, they said, although there is extensive Federal support for action in this area.

Chuck Hurley, executive director for Federal affairs for the National Safety Council, noted that the drunk driving issue has become "revitalized" because of a series of factors that have come together in the past several years, including citizen groups, bipartisan political support, media support, and the feeling that the recently announced National Commission on Drunk Driving will be able to raise further interest in the problem at the community level.

—John Small

Kansas Group to Study Drunk Driving Issues

Kansas Governor John Carlin has announced the formation of a special group to study the problem of drinking and driving in Kansas. The group, a subcommittee to the Kansas Citizens Advisory Committee on Alcohol and Other Drug Abuse, will deliver a final report in November 1982.

For further information, contact Judy Whitworth, Alcohol and Drug Abuse Services, Kansas Department of Social and Rehabilitation Services, 2700 West Sixth, Biddle Building, Topeka, KS 66606.

Prevention and Education Stressed in Detroit Sessions

The recent National Conference on Occupant Protection and Alcohol Countermeasures in Detroit featured several workshop sessions on alcohol education and prevention. According to James Malfetti, Ph.D., of Columbia University, drunk driving is the number one killer of America's young people, and as a result, alcohol and traffic safety education efforts need to begin very early. He urged that alcohol education begin in elementary school since, he said, that is where many attitudes are formed. He called for extensive testing and evaluation of such programs and urged educators to work closely with those in the alcohol field. "A variety of factors need to work toward an educated citizenry so that we can begin reducing drunk driving problems," Malfetti said.

He also suggested that alcohol education modules be developed to complement rather than interfere with basic education efforts. He said it is crucial that teachers be trained to use the curriculum and accompanying materials.

Peter Finn of Abt Associates in Boston (MA), who has developed a K-12 curriculum, said that alcohol education can be particularly successful in helping youths get insight into their own attitudes, exposing youths to alternative attitudes, promoting decisionmaking skills, serving a screening function for problem drinking youths, exposing children to the treatability of alcohol problems, serving a role modeling function, and transmitting facts about alcohol.

However, he noted that alcohol education in the schools is only one of several factors (along with parents, the media, and others) that influence childrens' attitudes. And, he said, there is no conclusive evidence that alcohol education alone can change long-term behavior.

Ann Johnson, Ph.D., director of program development in the Michigan Department of State, described the success that alcohol and safety education in the schools has had in Michigan, but said that such efforts "must be started early, since we all begin using the streets at a very young age." She cited bicycle riding and pedestrian use of the roads as areas that need to be targets of early prevention efforts. She said that communities should experiment and find out what works in the area. "No single education program is the answer," she said.

In another separate session, Georgia Waskovich and Win Rockefeller of the Arkansas State Highway Safety Program described an education and rehabilitation program that was set up for youthful offenders after a survey of the State's high school students indicated that 79 percent were drinkers and 75 percent had driven after drinking.

The Arkansas program has three components: a juvenile drunk driving education program, a kindergarten through 12th grade curriculum integrated into the schools, and a youthful offenders program. Educational sessions focus on the effects of alcohol on the body and the ability to drive, peer pressure, stress management, and parent-youth communication. In addition, parents attend the final session with their children. An evaluation of the Arkansas project is in progress and, according to Waskovich, preliminary results indicate the rate of rearrest among juveniles has dropped off since the program began.

— John Small

Doctors, Medical Students Learn About Alcoholism Through Program at Inpatient Treatment Facility

Since 1977, medical students and doctors have been learning about alcohol abuse and alcoholism through a physician education program at the Sundown M Ranch, a nonmedical intensive inpatient alcoholism treatment facility in White Swan (WA).

The program brings third-year resident medical students and physicians from the Yakima County (WA) Family Medicine Program — an adjunct to the University of Washington School of Medicine — to the alcoholism treatment facility for a 4-day series of educational sessions and workshops. The residents learn about the disease of alcoholism, philosophies of treatment, diagnosis and early intervention, alcoholism and the family, cross addiction, relapse, Alcoholics Anonymous (AA), and other topics. The residents also spend 4 hours at the local community alcohol center, where they are exposed to outpatient education and followup programs for the recovering alcoholic.

"The program is designed to give physicians alcohol education when they first experience frustration in treating alcoholics and are looking for solutions," says Pierre Brown, treatment director at Sundown M Ranch. "We also want to expose physicians to an emotional and close relationship with recovering alcoholics while they are engaged in specific learning experiences."

A recent State-funded study conducted by Fred A. Montgomery, M.D., Medical Director at Sundown, indicated that some changes in physician attitudes had resulted from the educational sessions. Montgomery began the sessions by administering a modified Weinberg questionnaire of 50 true/false questions designed to elicit physicians' ideas about alcoholism and their attitudes toward the alcoholic. After the program, physicians were posttested using a similar questionnaire.

According to Montgomery, prior to the sessions, nearly one-half of the respondents viewed alcoholism as resulting from personality or mental disorders. Afterward, 90 percent rejected this view. In addition, the educational experience significantly enhanced the view that recovery is an ongoing process, Montgomery said.

To date, 19 physicians and residents who commute daily have completed the program, which has no formal "semester" and is given on a request basis in consultation with the family medicine program. Many lectures are taught by Sundown counselors who also carry a caseload at the treatment facility. The physician education program is supported entirely by funds from patient fees.

For further information, or for a copy of the evaluation study, contact Fred Montgomery, M.D., Medical Director, or Pierre Brown, Treatment Director, Sundown M Ranch, P.O. Box 81, White Swan, WA 98952.

—Millree Williams

Alcohol, Cocaine Use Seen as Treatment Problem

Increasing abuse of cocaine may be creating a new set of problems for alcoholism treatment programs, says H. Alan Meyers, executive director of Pima Alcohol and Substance Abuse Rehabilitation, Inc., (PASAR) in Tucson (AZ). According to Meyers, the number of people using alcohol and cocaine simultaneously has increased substantially in the past few years. In addition, he says, persons who abuse cocaine are at high risk for becoming dependent on alcohol.

"Alcohol plays a very important role in the life of the cocaine-dependent individual," says Meyers, who has studied cocaine use in the United States and Peru. "Often, as the dependence on cocaine increases, alcohol is used more and more as a means of depressing the central nervous system so that cocaine consumption can continue. We have found that it is quite common for cocaine users to consume large amounts of alcohol, since they say it diminishes the anxiety and the depression associated with the temporary cessation of heavy cocaine use."

Even though some studies have shown cocaine to be not physically addicting, Meyers says the clients he has seen exhibit "devastating withdrawal symptoms, including shaking, acute anxiety, frustration, chills, and depression." Meyers also believes there are four distinct progressive levels of toxicity that accompany cocaine use: euphoria, disphoria, cocaine hallucinosis, and cocaine psychosis.

In the first, there is a feeling of heightened pleasure and the user is very verbal, lucid, and confident. In the disphoric phase, anxiety and depression begin to set in, and the user consumes increasing quantities of the drug in an attempt to maintain the original euphoria. The third stage, Meyers says, is accompanied by tactile, auditory, and visual hallucinations due to central nervous system overstimulation.

And the final stage brings symptoms similar to those that accompany true psychoses — paranoia, acute frustration, anxiety and depression, and the threat of suicide.

Most of PASAR's clients are referred by area courts, and all treatment programs, including individual and group counseling sessions, are offered on an outpatient basis only. As an introduction to treatment, PASAR uses a 4-week education program that Meyers says is crucial to helping clients understand the nature of their dilemma.

"Most cocaine and alcohol abusers think they are very knowledgeable about drugs," Meyers says, "but in reality they are often dangerously uninformed. A major goal in treatment is to get the clients' lives back in order. When they were drug dependent, they probably spent most of their time in a drug-seeking pattern, which is very destructive to relationships, jobs, and life in general." The educational sessions focus on the medical, physical, and psychological aspects of drug and alcohol use and are geared toward making clients more open to the treatment process.

In its treatment approach, PASAR concentrates on the alcohol problem first, and Meyers says disulfiram has been useful in some cases. After 6 drug-free months, clients begin attending once-a-month aftercare sessions where, Meyers says, "we can monitor clients and spot potential problems before they become major."

PASAR is funded by the Arizona State Department of Behavioral Health Services through the Pima Alcoholism Consortium and the Community Organization for Drug Abuse Control of Pima County, Inc.

For further information, contact H. Alan Meyers, M.A., Executive Director, Pima Alcohol and Substance Abuse Rehabilitation, Inc., 1320 East 22nd St., Tucson, AZ 85713.

— *Lisa Katz*

Magazine Provides Indepth Alcoholism Information

Where can you turn for information about innovative techniques and approaches in alcoholism prevention and treatment? For indepth examination of topics that directly affect provision of services in the alcohol field? For current research findings relevant to program planners and policy makers?

Alcohol Health and Research World has been the answer for thousands of alcohol program people, educators, medical professionals, and others in the human services field. The quarterly magazine of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), *Alcohol World* now brings you even more fresh, insightful, and informative articles and features — material written by and for people involved in alcoholism prevention, treatment, training, research, planning, and policy making.

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Most issues of *Alcohol World* contain a special focus section that provides facts and figures, opinions and viewpoints, and listings of resources for information, technical assistance, and funding related to the special focus topic. Beyond the special focus section, contributed features — useful, usable information about program approaches, clinical observations, state-of-the-art reviews, and the "how-tos" of translating theory into practice — cover a range of topics of interest to front line caregivers, planners, and managers. Updates on advances in alcohol research, reviews of significant new books, and news from the field are all regular features of *Alcohol World*.

Alcohol World is available only by subscription, for the low rate of $8.50 a year ($10.65 to foreign addresses). You will find it well worth the investment. Take time today to subscribe. Send a check, money order, or charge card authorization (card number and expiration date for VISA or Mastercard) to: Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

alcohol digest

Alcohol Digest is a collection of items of interest to the alcohol field.

Clearinghouse to Supply Training Materials

Effective immediately, all requests for training packages or materials developed by the National Center for Alcohol Education (NCAE) should be addressed to NIAAA's National Clearinghouse for Alcohol Information. The Clearinghouse will supply the following packages: *Counseling Alcoholic Clients, Initial Visit, Management Skills, Planning Alcoholism Services, Programming Community Resources, Services for Alcoholic Women, Training Alcoholism Trainers, Using Volunteers in Your Agency, You, Youth, and Prevention, Group Skills for Alcoholism Counselors,* and the *Decisions and Drinking* Series, which includes *Reflections in a Glass, The Power of Positive Parenting,* and *An Ounce of Prevention.*

The training materials are available free of charge to qualified individuals and groups and further information and order forms can be obtained from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852.

Voluntary Program Assists Lawyers

Members of the legal profession in the District of Columbia have set up a voluntary program to assist alcohol abusing and alcoholic lawyers. The Alcohol Assistance Program for Lawyers (APAL) is run by volunteer lawyers and has the support of the District of Columbia Bar Association.

The group has set up a special hotline for lawyers seeking assistance. Callers are then put in touch with two of APAL's trained volunteers who assess the circumstances and recommend an appropriate referral. Any concerned person may call and all inquiries are confidential.

For further information, contact Thomas Patton, c/o Schnader, Harrison, Segal, and Lewis, 1111 19th St. NW., Suite 1000, Washington, DC 20036.

Task Force Addresses Needs of Disabled

Educational and training materials on the disabled alcohol and drug abuser are available from the California Disability Substance Abuse Task Force. The group is composed of persons working in the fields of alcoholism, mental health, and the disabled (blind, deaf, developmentally disabled, paralyzed, orthopedically impaired, etc.) The task force also provides community education services, assists drug and alcohol programs in working with the disabled, refers individuals to treatment, and publishes a newsletter.

For further information, contact Pete Anderson, 12732 Jackson St., Garden Grove, CA 92641.

WANT TO GET BRIEFED?

In Briefs and **Fact Sheets**, produced by the National Institute on Alcohol Abuse and Alcoholism's Clearinghouse, explore specific alcohol topics and are highly useful support devices for people involved in alcohol-related work as well as people new to the field.

In Briefs are concise, 4- to 5- page summaries that offer background information and highlight current knowledge. **In Briefs** include topics of general interest, titles that are on special populations, and very specific status reports on current issues, covering a wide spectrum of alcohol information needs.

Fact Sheets give you the facts and nothing but the facts — specific pieces of alcohol related information at-a-glance, presented in the form of tables, charts, graphs, or maps.

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- ☐ Alcohol and the Elderly **(RPO 254)**
- ☐ Alcohol and the Family **(RPO 311)**
- ☐ Alcohol and Women **(RPO 276)**
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FACT SHEETS

- ☐ ABC Laws **(MS 202)**
- ☐ ABC Laws, Prohibited Hours of Sale **(MS 203)**
- ☐ Apparent Consumption of Alcoholic Beverages and Total Absolute Alcohol in U.S. Gallons Per Capita of the Population Over 14 Years of Age, By State: 1978 **(MS 236)**
- ☐ Credentialing of Alcoholism Counselors **(MS 231)**
- ☐ Decriminalization of Public Intoxication **(MS 204)**
- ☐ Estimated Patterns of American Adult Drinking Practices **(MS 207)**
- ☐ Facts on Alcohol Use Important to Industry **(RPO 100)**
- ☐ It's Dangerous to Mix Alcohol and Drugs **(ENCAS 7601)**
- ☐ State Dedicated Alcohol Taxes **(RPO 152)**

summer schools

JULY

July 5-23. Baton Rouge, LA. Institute on Addiction Studies. Contact the Training Department, Baton Rouge Chemical Dependency Units, Inc., P.O. Box 4109, 3968 North Boulevard, Baton Rouge, LA 70821.

July 11-16. La Jolla, CA. 11th Annual San Diego Summer Alcohol and Drug Studies Program, Contact Sue Pondrom, UCSD Exy., X-001, University of California, San Diego, CA 92093.

July 18-23. Durham, NC. Summer Institute of Alcohol Studies. Contact Fran Lineberger, Director, Summer Institute of Alcohol Studies, Duke University, Durham, NC 27708.

July 18-23. Greensboro, NC. North Carolina School for Alcohol and Drug Studies. Contact Bill Crawford, Fellowship Hall, P.O. Box 6929, Greensboro, NC 27405.

July 18-25. Grand Forks, ND. 24th International School of Alcohol Studies. Contact Thomas Hedin, Director, Division of Alcoholism and Drug Abuse, State Capitol, Bismarck, ND 58501.

July 18-25. Hamilton, Ontario. Institute on Addiction Studies. Contact Jean Fairbrother, Course Administrator, 15 Gervais Dr., Suite 603, Hamilton, Ontario, Canada.

July 19-23. Reno, NV. 14th Annual Nevada Substance Abuse School. Contact Angela Alaimo, Bureau of Alcohol and Drug Abuse, 5th Floor, Kinkead Bldg., 505 East King St., Room 500, Carson City, NV 89710.

July 19-23. Los Angeles, CA. UCLA Third Annual Institute of Alcohol and Drug Problems. Contact Terry Davis, Ph.D., 10995 LeConte Ave., Rm. 540, Los Angeles, CA 90024.

July 25-30. New Castle, DE. Delaware 11th Summer Institute on Alcoholism and Drug Abuse. Contact Paul Poplawski, Bureau of Alcoholism and Drug Abuse, 1901 North DuPont Hwy., New Castle, DE 19720.

AUGUST

Aug. 1-6. Salem, OR. Eleventh Annual Session of the Southern Oregon Institute of Alcohol Studies. Contact Ruthanne Lidman, Coordinator, Southern Oregon Institute of Alcohol Studies, 4540 Liberty Rd. South, Salem, OR.

Aug. 1-7. Fort Lauderdale, FL. Florida School of Substance Abuse Studies. Contact Richard Walker, Suite A, 417 South Andrews Ave., Fort Lauderdale, FL 33301.

Aug. 2-20. Baton Rouge, LA. Three-Week School on Addiction Studies. Contact Duncan Rose, Training Director, Baton Rouge Chemical Dependency Units, Inc., 3968 North Boulevard, P.O. Box 4109, Baton Rouge, LA 70821.

Aug. 9-13. Edina, MN. Project CHarlie Implementation Training Workshop. Contact Project CHarlie, 5701 Normandale Rd., Edina, MN 55424.

Aug. 15-20. Athens, GA. 22nd Southeastern School of Alcohol and Drug Studies. Contact Dr. W. E. Johns, Georgia Center for Continuing Education, University of Georgia, Athens, GA 30602.

Aug. 29-Sept. 3. Colorado Springs, CO. Sixth Annual Summer Institute of Drug Dependence. Contact the Institute for Integral Development, P.O. Box 2172, Colorado Springs, CO 80901.

NIAAA Information and Feature Service (IFS) is a service of the National Institute on Alcohol Abuse and Alcoholism. The opinions expressed in the articles do not necessarily reflect the view of NIAAA.

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Editor: John Small
Art Editor: Julie Kurz

meetings

JULY

July 11-16. Minneapolis, MN. Chemical Dependency and Adolescents. Contact the Johnson Institute, 10700 Olson Memorial Hwy., Minneapolis, MN 55441.

July 12-16. Somerville, MA. Teaching the CASPAR *Decisions About Drinking* Curriculum. Contact Lena DiCicco, CASPAR Alcohol Education Program, 226 Highland Ave., Somerville, MA 02143.

July 19-23. Minneapolis, MN. Group Seminar on Adolescents. Contact the Johnson Institute, 10700 Olson Memorial Hwy., Minneapolis, MN 55441.

July 19-23. Minneapolis, MN. Group Facilitators Training Workshop. Contact Community Intervention, Inc., 220 South 10th St., Minneapolis, MN 55403.

July 25-27. Hartford, CT. Second Annual Conference on Sports, Alcohol, and Drug Abuse. Contact John Woods, M.S.W., Conference Coordinator, 121 West Avon Rd., Avon, CT 06001.

July 26-30. Minneapolis, MN. Support Group Facilitator Training Workshop. Contact the Johnson Institute, 10700 Olson Memorial Hwy., Minneapolis, MN 55441.

July 29 – Aug. 1. Des Plaines, IL. International Doctors in Alcoholics Anonymous annual meeting. Contact Information Secretary, IDAA, 1950 Volney Rd., Youngstown, OH 44551.

July 31. Los Angeles, CA. The Family Album: Young and Adult Children of Alcoholics. Contact Gloria Kaufman, Human Development, UCLA Extension, P.O. Box 24901, Los Angeles, CA 90024.

AUGUST

August 2-3. San Diego, CA. Education and Prevention: A Conference on Developing Alcohol and Drug Education and Prevention Strategies in School Systems, Business, Community Services, and Through the Clergy. Contact G. Soroka, Coordinator, University of San Diego, Serra Hall, Room 200, San Diego, CA 92110.

Aug. 7. Los Angeles, CA. Advanced Workshop: Children of Alcoholics. Contact Gloria Kaufman, Human Development, UCLA Extension, P.O. Box 24901, Los Angeles, CA 90024.

Aug. 9-13. Detroit, MI. Beginning Alcohol and Addictions Basic Education Studies (BABES) Conference. Contact Martha Johnson, National Council on Alcoholism-Greater Detroit Area, 1800 Kales Building, 76 West Adams, Detroit, MI 48226.

Aug. 15-20. Minneapolis, MN. Chemical Dependency and Family Recovery. Contact the Johnson Institute, 10700 Olson Memorial Hwy., Minneapolis, MN 55441.

Aug. 27. Milwaukee, WI. Alcohol and Drug Issues and the Parish Ministry. Contact Dorothy Dow, Training Coordinator, DePaul Rehabilitation Hospital, 4143 South 13tn St., Milwaukee, WI 53221.

Aug. 29-Sept. 2. Nairobi, Kenya. Fourth World Congress for the Prevention of Alcoholism and Drug Dependency: Social Action Toward Prevention. Contact Ernest H.J. Steed, Executive Director, International Commission for the Prevention of Alcoholism, 6830 Laurel St., NW., Washington, DC 20012.

SEPTEMBER

Sept. 13-17. Brooklyn Park, MN. Evaluating Alcohol and Drug Programs: Current Methods and Findings. Contact Leslie Nyberg, Evaluation and and Research Department, Box 11, Center City, MN 55012.

September 14-17. San Diego, CA. Eighth Annual Conference for the American Association of Fitness Directors in Business and Industry: Themes for Creating Healthy Lifestyles. Contact Sheryl Marks, Program Chairperson, Conference Planning Headquarters, General Dynamics C.R.A., 9115 Clairmont Mesa Blvd., San Diego, CA 92123.

Sept. 15-18. Snowmass-Aspen, CO. Second Annual Workshop on Marketing Mental Health and EAP Services. Contact Sara Bilk, Director of Marketing and EAP Pograms, Colorado West Regional MH Center, P.O. Box 1580, Glenwood Springs, CO 81602.

Sept. 17-18. Milwaukee, WI. Intimacy and Sexuality Issues in the Delivery of Health Care Services. Contact Dorothy Dow, Training Coordinator, DePaul Rehabilitation Hospital, 4143 South 13th St., Milwaukee, WI 53221.

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June 30, 1982

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Sessions Highlight Approaches at Community Level

The NCA Forum

A Special Report

"Spotlight on the Community" drew more than 1,000 participants to the recent 1982 Forum of the National Council on Alcoholism (NCA) held in Washington (DC). The sessions highlighted proven and innovative approaches for solving alcohol and related problems at the community level.

Representatives of NCA's 220 affiliates, the health and social professions, business and labor, local, State, and Federal government, and the general public were brought together through the Forum. Special interest topics such as alcohol and traffic safety, diet in the treatment of alcoholism, and the contributions of anthropology to the study of alcoholism were addressed at a number of sessions. In addition, the American Medical Society on Alcoholism (AMSA), the Research Society on Alcoholism (RSA), the National Nurses Society on Alcoholism (NNSA), and the National Association of Alcoholism Treatment Programs (NAATP) sponsored meetings and symposia. Also, a variety of plenary sessions featured addresses by representatives of NCA and other groups.

In a keynote address, Edward N. Brandt, Jr., M.D., Assistant Secretary for Health in the Department of Health and Human Services (DHHS), discussed "New Opportunities for Progress." Stating that "none of us lives in a category," Brandt called on the delegates to tailor their efforts to the needs of, and the resources provided by, the communities in which they work. "We see that alcoholism detection and treatment programs can be most effective where they are part of a total community concern for adolescent and family health," Brandt said. As an example of how resources can be maximized, he cited "Healthy Mothers, Healthy Babies," a public information and education campaign organized by DHHS. The campaign promotes healthy behavior in pregnant women and women contemplating pregnancy and utilizes professional, voluntary, and governmental organizations.

Brandt stressed that the campaign represents "a peer relationship across the spectrum of community health services." In the coming years, he indicated, it will be the aim of "Healthy Mothers, Healthy Babies" and programs like it to "break down the artificial barriers between health programs" and thus enable persons working at the State and local levels to share information, skills, and resources. The block grant program will strengthen this process, Brandt said, by shifting health service responsibilities "away from Washington and out to the States" and allowing service programs "to be responsive to State and local needs." Brandt stated that the Federal Government is "passing the torch" to the States and said "it is essential that there be as little disruption of service as possible." He called on conference participants to help ease this transition and suggested that one way of doing so could be to "meet with leaders of medical education in your own areas and share with them your knowledge and experience."

Citing the contributions that research has made to the fight against the fetal alcohol syndrome (FAS), he said that the Federal Government plans to increase its support for research activities in the alcohol field.

Echoing Brandt's comments was William E. Mayer, M.D., Administrator of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), who spoke at the Forum's plenary session. Like Brandt, Mayer was optimistic about the results of government-supported research, saying that in the near future research should yield the kinds of data that truly are applicable to program needs. "We'll be able, not too far from now, to sort out those patients who don't respond to any kind of treatment, and figure out why," he explained. "Increases in research budgets can, if properly guided, yield results from not just labs and test tubes, but also from psychosocial research and other areas."

Mayer lauded the efforts of volunteers, and cautioned against any slow-down in these efforts. "In no other sector has the voluntary role been more important," he said, "yet there is still more to be done."

Other major issues Mayer pointed to include the need to step up efforts in epidemiological research and to educate lawmakers about alcoholism. Both Mayer and Brandt encouraged broader communication and application of new knowledge to the entire field. Brandt said that the field has "expressed more than once and in more than one forum the need to transfer the results of research so that they can be used in the real world of the family, the neighborhood, and the community." Brandt said this can be accomplished in the coming years through better publicizing of information by the government and increased cooperation between the alcohol and medical communities. Mayer, meanwhile, predicted that technology transfer assistance will soon become increasingly important to the field as the benefits of transferring information from State to State, community to community, and program to program become apparent.

For further information, contact Judith Wicks, National Council on Alcoholism, 733 Third Ave., New York, NY 10017.

—Jill Vejnoska

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On pages 7 and 8 of this issue is a mailing list update form which all readers must return to remain on the mailing list for the NIAAA Information & Feature Service. Please complete the form and return by September 30, 1982 to ensure uninterrupted service. Thank you.

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Researchers Report Findings On Current Alcohol Topics

Behavioral research studies were the focus of a symposium on current topics in human alcohol research at the recent National Council on Alcoholism (NCA) Forum in Washington (DC). Three investigators reviewed past studies and reported on their own work on the topics of tolerance, women and alcohol, and expectancy.

Tolerance

Peter Nathan, Ph.D., of the Rutgers University Department of Clinical Psychology in New Brunswick (NJ), reported on studies linking the apparent inability of alcoholics to determine when they have been drinking too much to the development of tolerance. Although some previous studies have concluded that chronic alcoholics could learn to discriminate moderate blood alcohol levels and not drink beyond these levels, Nathan's most recent study found just the opposite.

According to Nathan, four chronic alcoholics, trained for more than 15 days, could not learn to associate internal cues of intoxication, such as difficulties with balance, with rising blood alcohol levels. They could, however, figure out their blood alcohol level mathematically.

"It was concluded that these chronic alcoholics couldn't use internal cues but possibly could use external cues to determine intoxication," Nathan said.

Social drinkers who were tested appeared able to use both types of cues with equal ability. They also made more accurate estimates of blood alcohol level before training. "In other words, there appeared to be something about being alcoholic that rendered the individual not only unable to use internal cues but also grossly inaccurate in judgments on any basis," Nathan said.

Possible explanations for this difference between alcoholics and social drinkers included family history, drinking patterns, or tolerance development. To investigate further, the researchers measured 24 alcoholics for amount of body sway — a good measure of tolerance since the less the difference in body sway between the sober and intoxicated state, the more tolerant a person is assumed to be. They also gathered data on family history and drinking patterns. According to Nathan, half of the drinkers had a positive family history of alcoholism, the other half did not. Half of each of these groups were heavy social drinkers and the others were light drinkers.

However, the researchers found that neither family history nor drinking pattern predicted ability to discriminate internal cues of intoxication, but body sway (or tolerance) did, suggesting that inability to estimate blood alcohol level is a function of tolerance.

Also, the researchers concluded, a high tolerance to alcohol may be involved in the development of alcoholism. "If tolerance does not lead to dizziness or nausea, then this may be one reason that alcoholics can drink as much as they do in early years," Nathan said.

The investigators also decided to look at the other side of the coin, Nathan said, to assess the effect of tolerance on ability to experience the tension-reducing effects of alcohol. In 12 social drinkers, those with the highest tolerance showed the greatest reaction to stress, as measured by heart rate and skin response. Tolerance removes not only the negative but also the tension-reducing responses to alcohol, making it necessary to drink more and more to attain the same effect, Nathan said.

He concluded, "It may be a predisposition to early development of tolerance in the face of relatively little drinking for a brief period of time that renders a person, who perhaps may have inherited the predisposition, more likely to develop alcoholism than others without this predisposition."

Women and Alcohol

In another presentation, more evidence that the acute effects of alcohol on women differ in comparison with men was reported by Patricia E. Sutker, Ph.D., of the Tulane University School of Medicine and the Veterans Administration Medical Center in New Orleans (LA).

Sutker noted that very few studies have looked at the acute effects of alcohol on women, and only rarely have these been examined in comparison with men. Furthermore, most of the studies failed to control for phases of the menstrual cycle. Some of the work that has been done, however, suggests that women respond differently — behaviorally as well as emotionally — to alcohol or to the expectancy that alcohol is consumed than men. It has also been hypothesized that these differences may be related to the menstrual cycle changes, Sutker said.

In a study Sutker conducted, mood states were assessed in relationship to the menstrual cycle and alcohol consumption. Thirty-two moderate drinkers — including normally cycling women, women on oral contraceptives, and men — were asked to monitor mood, life events, alcohol consumption, body temperature, and menstrual cycle changes for 2 months.

Normally cycling women were found to drink to reduce tension less frequently than women maintained on birth control pills or men, and they drank more frequently to enhance pleasure than women taking birth control pills. The amount of alcohol consumed when drinking did not vary across phases of the menstrual cycle. Self-reported anxiety, hostility, and depression were found to be more elevated during the menstrual period, but not during the premenstrual phase, as many retrospective studies have reported. During the menstrual phase, the normally cycling women tended to drink more often to reduce tension tension than they did during the remainder of the cycle.

Preliminary findings of a second study by Sutker and her colleagues suggested that women may reach higher peak blood alcohol levels than men after drinking the same amount. However, in contrast with findings of previous studies, women did not take longer to reach these peak levels. Whether or not differences in alcohol metabolism exist between men and women remains an unanswered question, Sutker said.

Expectancy

G. Terence Wilson, Ph.D., of the Department of Clinical Psychology at Rutgers University in New Brunswick (NJ), reviewed studies looking at the effects that expectancy — or the belief that alcohol has been consumed — has on human behavior.

Expectancy has an especially significant impact on social behavior, Wilson said, and affects anxiety-related behav-

(continued on page 3)

Vocational Rehabilitation Focus of EPRA Program

The Employment Program for Recovering Alcoholics (EPRA) in New York City considers alcoholism treatment and employment a continuous process in the rehabilitation of the alcoholic.

EPRA, founded in 1977, is a nonprofit vocational rehabilitation service for men and women who are recovering from alcoholism. According to Executive Director Richard Masterson, who spoke at the National Council on Alcoholism (NCA) Forum in Washington (DC), "EPRA provides a comprehensive vocational rehabilitation service treating the multiple handicaps that often result from the illness process. This often involves social dislocation and economic dysfunction brought about by loss of a job or the inability to work steadily."

Clients often are referred to EPRA from treatment programs and from Alcoholics Anonymous (AA). Recovering alcoholics admitted to EPRA must be abstinent from alcohol and illicit drugs for a minimum of 90 days, unemployed and a resident of New York City, 18 years of age or older, free from active medical conditions or psychiatric symptoms that would pose serious limitations to employment, and involved in a program of recovery or other acceptable therapy.

The EPRA process begins with an intake interview designed to assess the individual's disability and employability. If additional alcoholism treatment is necessary, a referral is made. However, if it is not necessary, the client enters a 3-week diagnostic vocational evaluation, during which an assessment is made of any medical, psychological, social, or vocational barriers to employment. Each client then attends classes and discussion groups in the morning and individual counseling sessions in the afternoon. The program operates 4 days a week, and only one absence is allowed. After any additional absences, the client must begin the cycle again. A part-time employment component provides a source of income for those who need it during this period.

The evaluation also enables EPRA counselors to identify behavioral patterns that might affect the clients' abilities to gain employment and to assess the clients' abilities to concentrate.

The next phase of the program focuses on preparing the client for the working world. Two approaches are used — classroom training and transitional employment. In the classroom training, clients contact previous employers to clarify work references, develop a resume that honestly and favorably reflects on work history, develop interviewing skills, and conduct a job search. This phase normally lasts 3 to 5 weeks.

For those clients whose work history has been severely disrupted or who lack necessary interpersonal skills, a transitional employment period is recommended. The client is employed in a paid, part-time position with a not-for-profit employer and continues to attend job-preparedness training classes. These jobs are coordinated by EPRA staff, who say that employers have been supportive of the program's efforts.

Once the client has completed this program and has been referred to and gained employment, peer support group meetings are held 2 nights a week to assist in the individual's reentry. Followup with clients takes place 3, 6, and 12 months later.

As of December 1981, 571 individuals had entered the EPRA program. A 1981 survey of 118 clients enrolled in EPRA showed that 52 percent had been referred from treatment centers, while 48 percent came from AA; 69 percent were male; 70 percent were white, 25 percent were black, and 4 percent were Hispanic; and 55 percent reported relying on a government-supported income (Social Security, welfare, or unemployment benefits).

In addition, the ages of clients ranged from 19 to 62 with an average age of 37.3; the average length of sobriety was 18.8 months with a range of 3 months to 13 years; clients had been unemployed between 1 month and 7 years with an average length of 22.9 months; and 82 percent reported having a high school diploma or equivalent, while 16 percent were college graduates.

More than 50 percent of those who have enrolled in EPRA since the start of the program have returned to work or continued their education, Masterson said. Of the 103 who returned to work during the past year and a half, 93 were still employed as of March 1982.

Initial funding for EPRA came from a $15,000 seed grant from the Union Carbide Corporation. EPRA is administered by the New York City affiliate of the National Council on Alcoholism, and at present receives funding from the New York State Division of Alcoholism and Alcohol Abuse and the New York City Department of Employment and Office of Vocational Rehabilitation. EPRA employs a staff of 16, including 8 counselors.

For further information, contact Richard P. Masterson, Executive Director, EPRA, 360 West 31st St., New York, NY 10001.

—Jim O'Hair

(continued from page 2)

ior, aggression, self-disclosure, self-evaluation, and sexual arousal. "Indeed, at low levels of consumption, expectancy may be more important than blood alcohol level."

Expectancy studies reinforce the notion that beliefs and expectations about alcohol must be noted closely in treatment. "For example, if a patient believes fervently that a single slip will produce uncontrolled drinking, it's likely to become a self-fulfilling prophecy," he said. This leads to a whole set of therapies and strategies designed to develop the patient's coping abilities and to minimize relapse.

Alcoholics face many high risk situations following treatment. By assessing the psychosocial variables that influence how well the patient is equipped to deal with these situations, the therapist can better develop tools useful in preventing relapse. This already has been used to help people quit cigarette smoking, predicting when and in what type of situation relapse might occur, Wilson said.

For further information, contact Peter Nathan or G. Terence Wilson, Department of Clinical Psychology, Graduate School of Applied and Professional Psychology, Rutgers University, Busch Campus, New Brunswick, NJ 08903; or Patricia E. Sutker, VA Medical Center, Psychology Service, 1601 Perdido St., New Orleans, LA 70146.

—Nancy Johnson

Anthropologists Present Alcohol-Related Findings

A multifaceted, holistic approach to understanding alcohol problems characterized presentations at a symposium on "Anthropology: Contributions to the Study of Alcoholism" at the National Council on Alcoholism (NCA) Forum held in Washington (DC). The symposium was chaired by Linda A. Bennett of the Center for Family Research at George Washington University Medical Center in Washington (DC).

The broad scope of anthropology's past and potential contribution to alcohol research was reviewed by Jack O. Waddell of the Department of Anthropology at Purdue University in Lafayette (IN). Waddell emphasized the unique perspective offered by ethnographic studies that use qualitative measures (such as observations of social interaction, open-ended interviewing, and participation in social events) to describe human behavior. Anthropologists, he said, seek to explain behavior by investigating historical antecedents as well as the cultural and environmental contexts in which the behavior occurs.

Waddell discussed some of the ways ethnographic research can indicate pathways to prevention and recovery by focusing on the cultural genesis of alcohol use and problems. His examples included studies on the development of particular communities' drinking styles, the psychological and historical pathways to addiction in special populations, the degree of cultural synchronism between therapist and patient, theories of illness and recovery as reflected in linguistic and semantic systems, and the social dynamics of a treatment setting.

Subsequent speakers described alcohol-related behavior from an individual to a national perspective — discussing the skid row alcoholic, an inner city neighborhood gang or "crew," community agencies and facilitators, and a nation's (Papua New Guinea) drinking patterns. The following are brief descriptions of the presentations.

Public Inebriates

Treatment as a way of life for the skid row alcoholic in Illinois was described by Miriam B. Rodin of the School of Public Health at the University of Illinois Medical Center in Chicago; the coauthor was Lillian Pickup, R.N., a consultant to the Illinois Department of Mental Health and Developmental Disabilities Division of Alcoholism. The researchers used several sources of data to assess the effects of institutional changes in skid row (due to the Uniform Alcoholism and Intoxication Treatment Act which decriminalized public intoxication) on the adaptive strategies of chronic, indigent public inebriates. These included interviews with sober skid row alcoholics in Chicago, analyses of referrals to inpatient treatment from a Chicago detoxification center, and interviews with directors of Illinois' 24 detoxification centers, 4 of which are in Chicago.

With adoption of the Uniform Act in Illinois, jails and mental hospitals became less accessible to the skid row alcoholic, the researchers said. Their study showed that the resources needed by skid row alcoholics — food, shelter, clothing, and safety — were now most readily available through the alcohol treatment system and that the point of entry to the system had become the detoxification station. As a result, she said, their growing dependence on the alcoholism treatment system was found to be associated with increasing rates of recidivism. Referral records showed that repeaters had a better chance of being referred to inpatient rehabilitation, thus possibly encouraging recidivism, the presenters reported.

An Inner-City "Crew"

Alcohol use among members of a "crew" (group) of inner city youth was the focus of a paper presented by David Strug, and coauthored by Kevin Anderson and Joyce Ferman of Narcotic and Drug Research, Inc., a nonprofit corporation under the direction of the New York State Division of Substance Abuse Services. All eight crew members — Hispanic and black males ranging in age from 15 to 22 — were relatively heavy users of alcohol and marijuana.

The crew members said they used alcohol in conjunction with marijuana to "get nice," a state of euphoria that enhanced their pleasure in music, dancing, sports, and each other's company. Drunkenness was rarely an objective, and other drugs were considered dangerous and avoided. Although violent and criminal behavior were not directly associated with their drug use, crew members nonetheless did not regard themselves as "good" people. They defined "good" people as people who don't drink, don't use marijuana, and don't skip school.

Crew members lived in an impoverished minority community with disproportionately high rates of unemployment, morbidity, and mortality. Although crew members expected to finish high school and hoped one day to earn enough money to buy a "nice house," they considered their present environment dangerous, unresponsive to their needs, and lacking in educational or employment opportunities. Strug suggested that "getting nice" provided crew members with a means to establish a meaningful social group, to relax, and to enjoy themselves in the context of a life they regarded as dull, dangerous, and unhealthy. However, Strug warned, "The permissiveness of drinking and the extent of heavy drinking may be predisposing factors to the development of problem drinking later on."

Community Planning

The role of the anthropologist in community planning was the subject of a presentation by James M. Schaefer, Director of the Office of Alcohol and Other Drug Abuse Programming at the University of Minnesota in St. Paul. Schaefer acknowledged the usefulness of objective, quantitative studies as planning instruments, but argued that it is equally important to gain an understanding of how community institutional systems work. He showed how planners' constituencies are, in a sense, cultures, in that each has a "blueprint" — ceremonies, shared traditions, values, and goals that are passed on to and reinterpreted by the next generation. This is the case among organizations such as city councils, Lions clubs, school boards, or even Alcoholics Anonymous, he said.

Schaefer identified general contributions the cultural anthropologist can make to the implementation of community alcohol programs and policies. One is to describe the social dynamics of major community institutions and organizations. Another is to help members of these "diverse and often divergent" groups discover common objectives with respect to reducing levels of community alcohol abuse.

Social change achieved through organizational inter-

(continued on page 5)

Group Addresses Alcoholism Among Executives

Alcoholism among top-level executives is a major barrier to productivity in American business and industry, according to Paul Sherman, Ph.D., of Paul Sherman and Associates, a management consulting firm in Rye (NY).

Speaking before a labor-management meeting of the National Council on Alcoholism (NCA) Forum in Washington (DC), Sherman described Executive Case Management (ECM), a model approach to intervention with top-level executives who have drinking problems. ECM, Sherman said, utilizes a combination of management, organizational, and interpersonal techniques to analyze the effects of an executive's problem drinking, both on the individual and on the corporation.

A major sign of executive alcoholism is what Sherman calls "job shrinkage," where what an executive does continues to be good, but the executive begins to do fewer and fewer things as the alcoholism progresses. Superiors, co-workers, and secretaries increasingly cover up or explain away the problem drinking. This will continue for a number of years if intervention does not take place and, Sherman said, the job will erode to the point where there is little or nothing left.

Since executives often represent the company 24 hours a day, Sherman said, the executive's drinking can create problems outside the office. While such problems may be ignored at first, they can eventually become an acute situation for both the individual and the organization.

Intervention under the ECM model is based on the employee assistance program (EAP) concept. It involves individualizing an occupational program around the alcoholic that will best motivate that person to accept help and to recover. According to Sherman, changes are made in the job as well during the recovery process, and it is important to work on the individual and the job at the same time if maximum results are to be obtained. A key component, Sherman said, is to understand how the organization has been altered and affected to accommodate the person's drinking, and to make appropriate changes to correct this.

Sherman feels that the role of his organization is to assist the immediate superior in assessing the executive's performance; to help plan the confrontation of the problem executive with the superior; and to individualize a program of recovery for the executive, including a reorientation to the work environment and a one-year follow-up program. In executive case management, the client is the immediate supervisor or someone else designated in the organization — not the alcoholic. Sherman feels this precludes manipulation by the alcoholic and increases the probability of recovery.

During his 30 years in the organization development area, Sherman said he has participated in a great many interventions and has seen a success rate — defined as performance improvement for one year or more — of approximately 70 percent.

The reason for this rate of success, Sherman says, is the importance of the job. With alcoholism, the executive for many years has used the job as a measure that everything is all right, and the job over time has become for many executives the foundation of the denial system. The job can be used more effectively than anything else to break through this wall of denial that exists, Sherman said, and to motivate the person into a program of recovery. If handled properly, and with understanding of the subtle ways performance and the organization are affected, executives will respond to intervention, he said.

For further information, contact Paul A. Sherman, Ph.D., Paul Sherman and Associates, 150 Purchase St., Rye, NY 10580.

—Jim O'Hair

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action and cooperation requires the special skills of a facilitator, a role familiar to many alcoholism treatment counselors and to cultural anthropologists alike. According to Schaefer and his colleagues, Marianne Curry and Lois Yellowthunder, good facilitators are comfortable with people, nondefensive, imaginative, willing to share power and to allow others to take credit for ideas, aware of their own personal values and limitations, active listeners ("they hear between the lines"), sensitive to changes in mood and opinion, able to respect different frames of reference without being hostile or adversarial, and able to inspire trust.

Alcohol Policy

The use of anthropological research to develop a knowledge base for alcohol policies in Papua New Guinea was discussed by Mac Marshall of the Department of Anthropology at the University of Iowa in Iowa City.

According to Marshall, indigenous alcoholic beverages were unknown in Papua New Guinea and it was not until 1962 that a prohibition on alcohol use by natives was lifted by what was then an Australian administration. In 1979, four years after independence, the government allocated funds to obtain information on alcohol use and problems in the nation. Findings were expected to aid decisionmakers in developing alcohol control policies and legislation, and the project was administered through the country's Institute of Applied Social and Economic Research (IASER).

Papua New Guinea is the largest and most culturally varied country in Oceania, and more than 700 languages are spoken by its inhabitants. Since the formulation of an effective national alcohol policy had to accommodate a wide diversity of cultures, the IASER also sponsored an international conference at which 25 anthropologists focused on a wide range of social and cultural factors that influence alcohol consumption.

For further information, contact Linda A. Bennett, Center for Family Research, George Washington University Medical Center, Department of Psychiatry and Behavioral Sciences, 613 Ross Hall, 2300 I St., NW, Washington, DC 20037; Jack O. Waddell, Department of Sociology and Anthropology, Purdue University, Lafayette, IN 47907; Miriam B. Rodin, School of Public Health, Box 6998, University of Illinois at the Medical Center, Chicago, IL 60680; David Strug, Narcotic and Drug Research, Inc., Two World Trade Center, Rm. 6754, New York, NY 10047; James M. Schaefer, Director, Office of Alcohol and Other Drug Abuse Programming, University of Minnesota, 2610 University Ave., Rm. 360, St. Paul, MN 55114; or Mac Marshall, Department of Anthropology, University of Iowa, Iowa City, IA 52242.

—Cherry Lowman

Panel Debates Needs of Special Population Groups

Do special populations have special treatment needs?

"It's obvious that special groups do need special treatment," said Sheila Blume, M.D., director of the New York State Division of Alcoholism and Alcohol Abuse. "It is important to individualize treatment, but we should avoid stereotyping according to what some program person's perceptions of special groups are," commented Frank Iber, M.D., professor at the University of Maryland School of Medicine. The two debated the issue at the National Council on Alcoholism (NCA) Forum held recently in Washington (DC).

According to Blume, special treatment does not mean separate programs, but rather involves rearranging and adapting what is in place if it is not reaching special groups. She defined special populations as groups of people "united by a common factor of experience that shapes their alcohol problem and that determines factors relevant to their recovery." For instance, people for whom English is a second language cannot always participate fully in a treatment program in which only English is spoken; people who are deaf cannot understand completely the content of therapy that relies on concepts not translatable into sign language, even if an interpreter is provided.

Cultural Factors

Cultural factors must also be considered, she noted. The disease concept of alcoholism, for instance, is not perceived the same way by all cultures, so that counselors not aware of cultural differences may be unaware of misunderstandings on the part of clients. "Generally, when treatment fails, we blame ourselves for not doing enough, or blame the client for not trying," she said. "Often it is simply the fault of cultural miscommunication."

In some cases, special programming to accommodate the needs of special population groups is simple. "It's just a matter of thinking," she commented. "For example, many Jewish alcoholics have a hard time going to their first AA meeting because most AA meetings are held in churches and many Jewish people never have been in a church."

In other instances, identifying and meeting special needs is less simple. Special subcultures, bound by a common experience, may need specially focused treatment or aftercare programming, she suggested. Elderly alcoholics, for example, may need special support groups, since their attitudes toward alcohol and alcoholism differ from those of younger clients. Other special population groups, such as minorities, women, homosexuals, or the psychiatrically ill, may profit from specialized support groups as well, she said.

"The lack of research in this area means there are many unidentified special needs," she said. "Unless we identify and incorporate special programming sensitive to these needs, we will not reach, retain, or successfully treat these people." She called for research into which special populations need special treatment, which types of special programming are most effective with which groups, and how such programming can be accomplished efficiently.

On the other side of the issue, Iber contended that any alcoholism treatment program has to have elements that recognize the uniqueness of each individual, but said there is no evidence in the literature that specialized, separate treatment programs are more successful in treating special population groups than are general population programs.

A review of the research into the effectiveness of specialized treatment programs, he said, reveals that programs geared to serving a single special population group "consume resources but do not guarantee more effective treatment."

Counselor Involvement

The key to effective treatment, he said, is counselor involvement. "If the client feels that the counselor really cares, therapy is most likely to be successful," he said, noting that research indicated that, when the treatment staff and clients differ in their perceptions of what is more important to the treatment process, treatment outcome is less successful.

Providing effective treatment, he suggested, does not require homogeneity among counselors and clients. "It can, in fact, be useful if the counselor is from a different group than the client. It can provide a mirror, a different point of view," he observed. Sometimes, separate treatment for a special population can foster an "us versus them" attitude, creating a sense of unity by catalyzing a negative attitude, he said.

He argued that treatment programs should reflect the community they serve, and that separate programming for special populations should be provided only when it is justified by the magnitude of that special population in the program.

"There are a lot of things we agree on," Blume observed in a rebuttal. "We agree that splintering groups is not desirable, that it is wrong to think that only counselors of the same special population can treat clients from that group, and that a mature and well educated counselor is of key importance."

However, Blume took issue with the idea that special programming should be initiated only when a substantial number of clients representing a special group are involved in the program. "Sometimes we have to set up special programming if we want to attract a particular population we are not presently serving," she said. "We certainly won't get women with children into a program that doesn't offer appropriate care for their children."

"I believe we need broad community education in developing programming," Iber continued. Outreach that is directed to all segments of the community will build constituencies among special populations that can help to get people from these groups into treatment, he said. "There is very little documented that shows the special populations approach does work," he concluded. "If people are doing this successfully, they must document their results."

—Margaret Hindman

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Researchers Investigating Inherited Alcohol Problems

Two different forms of inherited alcohol problems that have distinct genetic and environmental causes have been identified by researchers working together at the National Alcohol Research Center at Washington University in St. Louis (MO) and the Umea University School of Medicine in Umea, Sweden. The National Alcohol Research Centers are supported by grants from the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

One type of alcohol problem is called male-limited because it tends to be passed only from fathers to sons. It is highly hereditary regardless of environment and limited to men whose natural fathers have records of extensive treatment for combined alcohol abuse and criminal behavior.

The other is referred to as milieu-limited because of the role environment plays in the frequency and severity of its development. It affects both men and women and is usually associated with mild alcohol abuse and minimal criminal behavior on the part of the natural parents.

The research was reported in two separate articles in *Archives of General Psychiatry* (Vol. 38, August 1981, pp. 861-868; and September 1981, pp. 965-969). The findings are based on an extensive examination of medical and social records of 862 males and 913 females born in Stockholm, Sweden, from 1930 to 1949 and subsequently adopted. Sweden was seen as an ideal site for an adoption study because adoption records are more extensive there than in other countries. The 10-year study began in 1970.

Data collected on each of the adoptees and their biological and adoptive parents came from records of treatment or other intervention for problems, criminal behavior, and occupational status.

The study clearly shows that both hereditary and environmental factors play a role in the development of alcoholism. The researchers found that, if the natural parents of the adopted children were alcoholic, the children ran a greater risk of becoming alcoholic despite being raised by nonalcoholic adoptive parents. However, if the natural parents were not alcoholic and the adoptive parents were, the risk was not increased.

The study is also the first to show that women as well as men inherit such problems, according to C. Robert Cloninger, M.D., professor of psychiatry and genetics at the Washington University School of Medicine, who became involved in the data analysis 3 years ago.

The researchers used the information not only to show that alcohol problems were inherited, but also to distinguish two different types of inherited problems and to examine how environment influenced risk. "It's one of the few studies to clearly separate environment and genetics and to look at how they interact with one another," said Cloninger.

The male-limited form of alcohol abuse accounted for only about 24 percent of the adopted men with alcohol problems in the study. Passed from father to son, this type of alcohol abuse was highly hereditary despite adoptive environment. Drinking problems of the fathers of this group began early in life — usually in adolescence — and recurrent abuse often interfered with work and marriage and led to crimes of violence such as assault and wife beating. Sons of this type of alcoholic faced a ninefold increase in risk. About 18 percent of the sons of men with this type of alcoholism developed alcohol problems, compared with about 2 percent of the general population, Cloninger said.

Although environmental factors seemed to have little effect on the risk of developing this type of alcohol problem, they may have influenced the severity of the problem. The natural fathers of these adoptees had a record of extensive treatment for alcohol problems while the sons had a record of recurrent problems but not treatment, indicating, possibly, a milder form of illness, the researchers said.

A much more common type of alcohol problem, the milieu-limited form, affected 76 percent of the men and all of the women with alcohol problems whose natural parents had alcohol problems. Although susceptibility was hereditary, environmental factors had significant impact on both frequency and severity of the problem, the researchers said.

The risk among the male adoptees of developing this type of alcohol problem varied from 13 to 26 percent, depending upon environment. Although "alcohol abuse is mild in most such cases and usually does not require treatment . . . more severe disability requiring hospital care may occur in susceptible sons who are exposed to particular postnatal environments, especially sons from the sociocultural background associated with low occupational status," the researchers said.

The biological fathers of these men had a history of heavy drinking that began in their 20s or 30s and gradually progressed to a state of physical dependence in middle age. The fathers may have had medical problems associated with their drinking, but were usually able to maintain jobs and families. Problems were mild, criminal behavior was minimal, and often there was no history of treatment. The natural mothers of adoptees with this type of problem, in contrast with the mothers of those with the male-limited form, sometimes also had a history of mild alcohol problems and convictions for minor crimes.

This milder milieu-limited type of alcohol problem also appeared to be inherited by women, most often from their mothers. Among adopted daughters whose natural parents had alcohol problems, 6.7 to 7.7 percent (depending on environment) developed alcohol problems compared with 2.3 percent in the general population.

Although both fathers and mothers with mild forms of problems had daughters who became alcoholic, daughters whose mothers had problems stood out as much more susceptible.

For further information, contact C. Robert Cloninger, M.D., Department of Psychiatry, Jewish Hospital, P.O. Box 14109, St. Louis, MO 63178.

— Nancy Johnson

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Presidential Commission Holds First Meeting

Acting on President Reagan's call for "results, not another study," members of the Presidential Commission on Drunk Driving convened in Washington recently for their first meeting. The 30-member commission, chaired by former Department of Transportation (DOT) Secretary and former Massachusetts Governor John A. Volpe, was established by the President this spring and includes representatives of alcoholism organizations, local, State, and national political figures, citizens involved in the issue, medical professionals, and business and labor leaders.

In opening remarks, DOT Secretary Drew Lewis said the Commission's existence reflects "the importance the administration attaches" to curbing drunk driving. According to Lewis, 340 members of Congress signed a letter urging President Reagan to form the Commission, whose aims, Lewis explained, are threefold: to create greater public awareness of the drunk driving problem; to inspire more activity by State and local governments; and to generate public support for these efforts. National Highway Traffic Safety Administration (NHTSA) Administrator Ray Peck pledged NHTSA's "full commitment of resources to the Commission's work."

Volpe noted similar commitment on the part of Commission members, applauding their "willingness to serve our Nation in one of our worst tragedies." Volpe then outlined four basic approaches to reducing drunk driving that he said the Commission will consider: public information, raising the perceived risk of arrest for drunk driving, possible increases in the severity of punishment, and education and rehabilitation. "In summary," Volpe said, "we have made drinking and driving socially acceptable in this country and we have to make it unacceptable." The Commission, he concluded, has "a real job to do to bring this problem to public awareness 365 days a year."

Volpe described the Federal Government's role in this process as "indirect, supportive action," and said that State and local governments will be expected to play major roles in the effort. The Presidential Commission's role, he explained, will be "to stimulate and catalyze effective programs within the States . . . by communicating efforts that are successful." Rather than mandate specific courses of action, the chairman continued, "the Commission will say, 'here are the types of programs that are successful, and here's how you could achieve similar success.' " In this way, he said, the Commission will "serve as a clearinghouse for sharing information with communities."

In brief introductory statements made at the conclusion of swearing-in ceremonies, Commission members shared their ideas. Sherman G. Finesilver, a judge of the United States District Court in Colorado, commented that he has "never seen the climate better" for combating drunk driving, particularly now that congressional and presidential support for such efforts exists. New York State senator William T. Smith — who recently chaired the New York Senate Special Task Force on Drunk Driving — indicated that the situation has changed since 1973 when, having lost a daughter to a drunk driver, he tried to bring this issue to the public's attention, but found "the time wasn't right." James S. Kemper, Jr., chairman of the board of the Kemper Group of insurance companies, concurred, but cautioned, "This Commission has an interest right now that will be lost if we don't act on it."

The Presidential Commission will study major issues affecting drunk driving for 1 year, at the end of which, Volpe said, it will issue a report to the President. While the report will contain only recommendations, the Commission's final objective is to reduce deaths and injuries due to drunk driving.

The following individuals were chosen to serve on the Presidential Commission on Drunk Driving: V. J. Adduci, president and chief executive officer of the Motor Vehicle Manufacturers Association of the U.S., Inc., in Washington, DC; Van Henry Archer, Jr., a city council member in San Antonio, TX, and a stockbroker with George E. Dullnig Company; Ross Barrett, senior vice president and senior corporate officer on the West Coast for Metromedia, in Los Angeles; Michael D. Bradbury, district attorney for Ventura County in California; Morris E. Chafetz, M.D., president of the Health Education Foundation in Washington, DC; Joseph M. Dealy, chairman of the board of A.H. Belo Corporation and publisher of *The Dallas Morning News*; James R. Edgar, secretary of state of Illinois; Sherman G. Finesilver, district judge, United States District Court in Colorado; James S. Kemper, Jr., chairman of the board, Kemper Group, in Long Grove, IL; Henry B. King, president of the U.S. Brewers Association, Inc., in Washington, DC; Patience Latting, mayor of Oklahoma City, OK; Ann Landers, syndicated human relations columnist, Chicago; Candace Lightner, of Fair Oaks, CA, president and chief executive officer of M.A.D.D. (Mothers Against Drunk Driving); Forst Lowery, safety program coordinator for the Minnesota Department of Public Safety; G. W. Hank McCullough, self-employed in real estate and communications and a founder of the Alcoholism Council of California and its president for the first 5 years; Frederick A. Meister, Jr., president of the Distilled Spirits Council of the United States, Inc., in Washington, DC; William N. Plymat, executive director of the American Council on Alcohol Problems in Des Moines, IA; Joseph A. Pursch, M.D., corporate medical director and member of the board of directors of Comprehensive Care Corporation (CompCare) and in private practice in Laguna Niguel, CA; Walter Shea, executive assistant to Teamsters Union general president Roy L. Williams; Milton Skyring, project director of Checkmate, Baton Rouge city court, LA; William T. Smith II, of the New York State Senate and chairman of the Senate Special Task Force on Drunk Driving; Stan Statham, State assemblyman in California; Vincent L. Tofany, president of the National Safety Council; Dick Vincent Van Patten, an actor in Beverly Hills, CA; and Frank D. White, Governor of Arkansas. In addition, the majority leader of the Senate and the Speaker of the House have designated two members of each House of Congress to participate. They are Senator Robert Dole of Kansas, Senator Claiborne Pell of Rhode Island, Representative James V. Hansen of Utah, and Representative Michael D. Barnes of Maryland.

— Jill Vejnoska

Health Insurance Column

Study Gathers Treatment Information

The St. Paul-Ramsey Hospital Medical Education and Research Foundation of St. Paul (MN) recently began a study at six hospital alcohol and drug treatment programs in the Minneapolis-St. Paul area to determine the impact of alcohol and drug abuse treatment on job performance and medical utilization. The first phase of study, which involved 1,400 former inpatients, compared data gathered before treatment with data gathered 6 months after treatment.

In the first phase of the study, researchers say there was a reduction in hospitalization, arrests, and unemployment. Specifically, employment increased by 17 percent; absenteeism on the job decreased by 87 percent; job performance problems decreased by 92 percent; hospitalization for medical diagnoses decreased by 39 percent; hospitalization for psychiatric diagnoses decreased by 71 percent; and arrests decreased by 85 percent. The study is expected to last 3 years (January 1980 through January 1983) and to include approximately 3,000 adult patients who have been treated in chemical dependency programs in an inpatient setting. A final report is expected in late 1983.

For further information or for a copy of the results, contact Norman G. Hoffman, Ph.D., Director, Chemical Abuse and Addiction Treatment Outcome Registry (CA TOR), Department of Psychiatry, St. Paul-Ramsey Hospital Medical Education and Research Foundation, 640 Jackson St., St. Paul, MN 55101.

CHAMPUS Begins Demonstration Project

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) has initiated a 3-year demonstration project to assess the relative advantages and disadvantages of offering alternative health benefit plans to persons eligible for CHAMPUS. Under the current health benefit system, the major portion of the medical services for CHAMPUS members (dependents of active duty members, retired members and their dependents, and the survivors of deceased service personnel) is provided by the medical departments of the uniformed services when space is available and, with certain limitations, by civilian providers.

CHAMPUS members who participate in the demonstration will be offered a choice between the current system of health benefits and membership in participating health maintenance organizations (HMOs) and private health insurance plans. The demonstration will be used to evaluate the degree to which the availability of choice improves the health benefit system for CHAMPUS members and/or reduces the cost of health care services.

CHAMPUS plans to evaluate this effort and information will be collected about the choice of health benefit plans, utilization and costs of health care services including alcoholism treatment, and demographic characteristics of participating CHAMPUS subscribers.

The project began in Portland (OR) in September 1981 and additional sites will be added within a 36-month period.

For further information, contact Joseph C. G. Smith, LTC, USAF, Chief, Health Systems Research Branch, CHAMPUS, Aurora, CO 80045.

NIAAA Study Gathers Health Insurance Information

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has completed a study of legislative developments related to health insurance coverage of alcoholism treatment services. The study was designed to gather information from States about legislation mandating or requiring the offering of health insurance that includes coverage for alcoholism treatment services.

The study found that as of Sept. 30, 1981, there were 33 States with laws regulating insurance coverage for alcoholism. Of these, 17 States included mandatory coverage, while another 16 required health insurance carriers to make such coverage available on an optional basis. Five of the 33 States required some combination of mandatory and optional coverage. Eighteen of the State statutes applied to health maintenance organizations.

Legislative alternatives that States might want to consider in the future are presented and discussed in the report.

A final report, "Status of State Legislation and Research on Health Insurance Coverage for Alcoholism Treatment," is available in limited quantity. For a single copy, write to the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852.

Blue Cross Group Issues Report

Blue Cross of Greater Philadelphia (PA) recently issued a report entitled "Joint Health Cost Containment Program: Hospital Utilization Report," which documents the changes in utilization of health services by the 311,000 employees and their dependents from 37 participating Tri-State (Pennsylvania, New Jersey, and Delaware) (PENJERDEL) employers whose combined expenditures for hospital care in 1980 totaled $76 million.

The study found that the PENJERDEL employees utilized 3 percent of their hospital days in 1980 for alcohol and drug abuse treatment. Hospital days used for alcoholism treatment amounted to 18.7 per 1,000 subscribers. The average length of stay for alcoholism in 1980 was 14.3 days, and the average allowable charge per admission was $1,696.

In addition, a sample study revealed the average stay for identified alcohol and drug abusers with hospitalization for other illnesses was 9.5 days as compared with 6.4 days for the rest of the subscriber population. Seventy percent of the other illnesses were related to or caused by their addictions, the report states.

Blue Cross of Greater Philadelphia is one of three Blue Cross Plans participating in a demonstration project to develop and market comprehensive alcoholism and drug abuse treatment benefits to their subscribers. The effort is supported by the National Institute on Drug Abuse (NIDA) and NIAAA through a contract to the Blue Cross/Blue Shield Association. Based on the results of the demonstration project, the association may expand the benefit to other Blue Cross plans.

For further information or for a copy of the executive summary of the report, contact Leonard Davis, Senior Director, Quality Assurance, Blue Cross of Greater Philadelphia, 1333 Chestnut St., Philadelphia, PA 19101.

— From NIAAA

WIP Combines Intervention With Physician Education

Officials in 10 southwest Ohio counties have combined alcohol education for medical students with a 3-day intervention/education program for the drunk driver. The Weekend Intervention Program (WIP) has provided counseling to more than 2,000 persons arrested for drunk driving in the past 3 years and afforded hundreds of medical students a chance to learn about alcohol problems and alcoholism.

The WIP is run by Wright State University in Dayton (OH), in cooperation with the courts, police, and various alcoholism groups. The program runs from Friday afternoon to Sunday evening and a "typical" class is 40 to 50 people—first-time and repeat drunk driving offenders. Medical students and faculty sit in as observers, a technique that, according to program director Harvey Siegal, Ph.D., has proved most beneficial for the students.

Originally, the WIP was aimed at repeat drunk driving offenders, but officials soon found the program had implications for first offenders. According to Siegal, preliminary evaluation data have shown that 91 percent of those who attended WIP sessions have not been rearrested for driving while intoxicated (DWI). In addition, 27 percent of attendees say they have been abstinent for 6 months, while another 63 percent say they are now drinking less than they were before the sessions. Only 2 percent say they are now drinking more.

In addition, the program is entirely self-supporting. In the cases of first offenders, the judge may reduce the charge to reckless operation with a provision that the offender attend the WIP classes. To cover the cost of the program ($175), judges can suspend all but $175 of the fine, subject to the completion of the program.

Clients report to the Wright State University Medical School Friday at 4 p.m., at which time a medical and alcohol history is taken. Then the group hears an introductory lecture by Siegal, who is also associate professor and vice chairperson of the Department of Medicine in Society at the Wright State University Medical School. Siegal discusses the disease of alcoholism, denial, defense mechanisms, and group therapy techniques. Participants see films and participate in group counseling until 11 p.m., when they are transported to a local motel (cost included in the fee) where they spend the night.

"By the end of Friday night, we have a pretty good idea of who has a drinking problem," Siegal says. "Fatigue also works for us on Friday night. The strangeness of the setting and the close scrutiny make it hard for people to disguise their problems."

An important aspect of the WIP, according to Siegal, is that groups are usually heterogenous, with repeat offenders and first-timers mixed. This, says Siegal, "seems to have a positive effect on the clients. Many (clients) use the perspective gained through counseling sessions to grasp the seriousness of their own involvement with alcohol. Someone might think, 'hey, if I don't look at my own drinking, that's me 10 years down the road.' "

The counselor selection process is also very important, Siegal says. A high counselor-to-client ratio—2 professional counselors (medical doctors, licensed psychologist, or master's level social worker or certified alcoholism counselor) for each group of not more than 12 clients—is carefully maintained. Groups are typically cofacilitated by an academically credentialed counselor (M.D., Ph.D., M.S.W) and a recovering alcoholic or drug abuser.

"The students who sit in turn right on," Siegal says. "Medical students begin asking for contact with patients from their first day of school. The WIP allows for real contact and gives the students a firsthand look at alcoholism and problem drinking."

Although participation by the medical students is voluntary, more than 40 have signed up so far. Currently, students can receive academic credit for their time, and a proposal has been endorsed by a faculty review committee that would make the WIP part of the medical school required core curriculum.

Also, those medical students who participate in the program several times and receive special training can apply to be junior counselors and get paid for their work. According to Siegal, 15 students have done so. "Active learning is the key," he says. "This gives them a chance to have real hands-on experience."

When the clients return at 6:30 on Saturday morning, they hear lectures, see movies, and are involved in group counseling. On Saturday afternoon, the clients attend a presentation on alcohol's effects on the body. Each educational activity is following by group or individual counseling to assist the client in relating to the information he or she has received. The focus of much of the group work is on those individuals who the counselors believe to have a problem. Initial offenders, in whom there is no evidence of an actual or developing problem, receive the benefit of the sessions, along with special educational materials.

On Sunday, the clients return to the medical school early in the morning. At this time, counselors work out an appropriate treatment plan with the clients who need additional assistance. "Assuming someone has a (drinking) problem, we recommend either inpatient treatment, mental health counseling, pastoral counseling, Alcoholics Anonymous (AA), or some other form of assistance, he says. In addition, the WIP provides a complete report to the referring court within 96 hours.

Also at this time, the counselors gather data that is used for program evaluation. The clients are informed that they will be contacted 6 months later for additional data.

"By the end of the weekend," Siegal says, "we hope that the client will have learned much about alcohol, alcoholism, and alcohol problems. More significant, the client—as a result of the program experience—will have confronted and examined his or her own behavior.

"We don't try to convince someone that he or she is alcoholic or a problem drinker. If—at the end of the weekend—someone says, 'I guess that when I drink, things happen to me that I don't like or 'when I drink, I seem to argue with my spouse,' we feel we have made progress. Without intervention, people often don't see the extent of their involvement."

For further information on the WIP, contact Harvey A. Siegal, Ph.D., Director, Weekend Intervention Program, Wright State University School of Medicine, Dayton, OH 45435.

—John Small

FAS Researchers Studying Increased Public Knowledge

A decrease in reported alcohol use among Seattle's pregnant women seems to correspond to an increase in overall public knowledge about the risk to normal fetal development posed by maternal alcohol use, according to Ann P. Streissguth, Ph.D., and her associates at the University of Washington in Seattle. The researchers found a marked decrease in alcohol use among pregnant women studied in 1980-81 as compared with a similar group studied in 1974-75, before national publicity brought fetal alcohol syndrome (FAS) to the public's attention. Preliminary findings from the comparative study were presented by Streissguth in a symposium on the epidemiology of alcohol use at the 13th annual Medical-Scientific Conference of the National Council on Alcoholism (NCA) Forum held in Washington (DC).

FAS was first described in the medical literature in 1973 and was reported by the Seattle news media shortly before the 1974-75 study was conducted. In 1977, an advisory issued by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) warned pregnant women not to drink more than two drinks a day. The Surgeon General's warning came after this study. (See IFS #89, Oct. 28, 1981).

The studies of 3,000 women — 1,500 before and 1,500 after — were drawn from the same two hospitals and were comparable with respect to mothers' age, education, and income. The samples did vary, however, along two dimensions: there were both more black mothers and more single mothers in the 1980-81 sample.

In the 1980-81 study, pregnant women were interviewed during their first prenatal visit so that their drinking behavior at the time of the interview would reflect public knowledge about drinking during pregnancy and not medical recommendations. In Streissguth's words, the data "showed what these women were doing before someone told them what they ought to be doing."

The researchers found that alcohol use had decreased between 1974 and 1981 among most subgroups of pregnant women studied. In addition, the greatest dropoff occurred among college-educated and professional women, suggesting they may have had more access to information about FAS.

In order to assess the kind of mental shift women make regarding appropriate levels of alcohol use when they learn they are pregnant, the researchers asked about drinking practices at the time of conception (before respondents knew they were pregnant) and drinking practices at the time of the interview (after respondents knew they were pregnant).

The researchers found that there had been a large increase in the proportion of women who were alcohol abstainers around the time of conception (before they knew they were pregnant) — from 20 percent in 1974-75 to 35 percent in 1980-81. They also found a decrease in alcohol use among women in all drinking levels once they learned they were pregnant. Decreases in alcohol use after knowledge of pregnancy were reported by the 1980-81 sample for all types of alcoholic beverages.

Streissguth cautioned against generalizing these results to other areas because, she said, Seattle was a unique city due to the presence of a large FAS prevention program, ongoing during the past three years.

Patterns of Use

In the same symposium, Marcia Russell, of the Research Institute on Alcoholism at the New York State Division of Alcoholism and Alcohol Abuse, reported on a study investigating differences in patterns of alcohol use among black and white women (including pregnant women) in Buffalo (NY). The study group consisted of more than 2,000 obstetric and gynecologic patients at four outpatient sites who had filled out questionnaires on alcohol consumption in 1978 and 1979.

According to Russell, black women reported higher rates of abstention and infrequent drinking and lower rates of moderate drinking than did white women; rates of heavier drinking were found comparable in the two groups. However, employed white women were found to drink significantly more heavily than employed black women, but the opposite relationship was found among housewives. These differences characterized married and unmarried women alike.

In contrast with Seattle, there had been relatively little publicity in Buffalo about the effects of drinking during pregnancy prior to the study, and Russell added that she considers the data a suitable baseline for assessing the influence of current and future FAS prevention programs.

The data did indicate a need for what Russell termed "medical social controls" — those that exert their influence on levels of alcohol use by way of medical advice. About 10 percent of the pregnant women in the study reported they drank an average of at least two drinks a day (1 ounce of absolute alcohol) during the month prior to learning they were pregnant and 4 percent drank an average of six or more drinks a day. Because the percentage is not significantly lower than the national average for women of this age, Russell believes the women in Buffalo showed no tendency to prepare for pregnancy by diminishing alcohol intake. Recent embryological research, she said, suggests that some fetal alcohol effects may occur as early as the third week of gestation, well before women realize they are pregnant. Thus the Buffalo study indicates a real need for "medical social controls" on alcohol use among women who are planning pregnancies as well as among those who are already pregnant, Russell said.

Since these studies, the presenters noted, numerous FAS prevention campaigns have been mounted, including one by NIAAA in conjunction with State governments and local and voluntary organizations, and one by the New York State Division of Alcoholism and Alcohol Abuse. Thus, they said, there will be future opportunities for researchers to study the impact that these efforts may be having in reducing FAS among pregnant women.

For further information, contact A. P. Streissguth, Ph.D., Department of Psychiatry and Behavioral Sciences, Division of Child Psychiatry, GI-80, University of Washington, Seattle, WA 98105; or Marcia Russell, Ph.D., Research Institute on Alcoholism, New York State Division of Alcoholism and Alcohol Abuse, 1021 Main St., Buffalo, NY 14203.

—Cherry Lowman

alcohol digest

Alcohol Digest is a collection of items of interest to the alcohol field.

NIAAA Monographs Now Available

Two new volumes in the National Institute on Alcohol Abuse and Alcoholism's (NIAAA) research monograph series are now available from the Government Printing Office (GPO). Research Monograph No. 6, *Development of Animal Models as Pharmacogenetic Tools*, surveys the literature in pharmacogenetics generally and in behavioral pharmacogenetics specifically. A copy of the monograph can be obtained for $7 by requesting stock number 017-024-01124-0. Research Monograph No. 8, *Occupational Alcoholism: A Review of Research Issues*, reviews the state of the knowledge, discusses research issues, and makes recommendations for future research in the area of occupational alcoholism. A copy can be obtained for $9.50 by ordering stock number 017-024-01126-6.

Both of these monographs can be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

Program Assists Impaired Dentists

A program to offer assistance to dentists who suffer from problems involving alcohol or other drugs has been implemented by the Maryland State Dental Association. Problems are approached in a manner that is nonjudgmental, nonpunitive, and therapeutic. Since the program's inception in January 1981, 22 dentists have been assisted by the program. Program administrators say that similar efforts are underway in at least 13 other States.

For further information, contact Mark S. Arthur, D.M.D., Department of Pharmacology, University of Maryland Dental School, 666 West Baltimore St., Baltimore, MD 21201.

Test Seeks to Screen Children of Alcoholics

A 30-item "Children of Alcoholics Screening Test" has been developed by John Jones, Ph.D., director of psychological research for London House Consultants in Park Ridge (IL) and a counselor of adolescents from alcoholic families.

The test is designed to identify children of alcoholics in schools and clinics, and can be administered by counselors, treatment professionals, or social workers. The test is available for $5 and comes with a preliminary test manual, a brief literature review, and information on scientific and statistical validation.

For further information, contact John Jones, Ph.D., Director of Psychological Research, London House Consultants, Inc., 1550 Northwest Hwy., Park Ridge, IL 60068.

Texas Group to Study Alcoholism in State

The Texas Commission on Alcoholism (TCA) has awarded a $149,119 contract to the Texas Christian University to conduct a major study of the incidence and prevalence of alcoholism in the State. The contract, the largest ever awarded by the agency, will be funded with Federal block grant funds. The study is expected to provide data to assist TCA in program development throughout the State and also to improve cost efficiency.

For further information, contact Jane Maxwell, Texas Commission on Alcoholism, Eighth Floor, Sam Houston State Office Bldg., 201 East 14th St., Austin, TX 78701.

Public Inebriate Report Available

Proceedings and further findings from the first National Conference on the Public Inebriate now are available. The conference, held in 1980, was sponsored by the National Coalition for Jail Reform, the National Association of State Alcohol and Drug Abuse Directors, and the National Council on Alcoholism. *The Public Inebriate: Overview and Alternatives to Jail* is a 44-page book that addresses current social and legal issues surrounding the public inebriate. The cost is $5 and all orders under $10 must be prepaid. For further information, contact the Wisconsin Clearinghouse, 1954 East Washington Ave., Madison, WI 53704.

American Samoa Programs Developed

Since 1977, officials in American Samoa have been taking steps to address the problem of alcohol abuse and alcoholism among the 30,000 residents of this American territory in the South Pacific.

Although the population is small, officials say that per capita consumption of alcohol is higher than in the U.S. Through the cooperative efforts of the American Samoa Office of Traffic Safety and the Department of Education and of researchers at Texas A&M University's Safety Education Program, a series of alcohol education programs have been developed.

In 1977, an alcohol education workshop was developed for public school teachers and, in 1978, an alcohol education curriculum was developed for use in secondary schools. In 1981, work began on a similar curriculum package for junior high schools, and future plans call for a curriculum package for elementary schools.

For further information, contact Maurice E. Dennis, Ph.D., Director, Safety Education Program, Texas A&M University, College Station, TX 77843.

Primary Prevention Curriculum Developed

The Mount Auburn Hospital Alcohol Education and Training Center in Waltham (MA) recently teamed up with the Arlington (MA) school system to develop *Making Friends, Making Choices*, a primary prevention curriculum for grades three through six.

The curriculum includes 53 lesson plans that can be adapted for use in numerous subject areas, including reading, social studies, art, health, or language arts. The lesson plans promote students' decision-making and interpersonal skills and explore alcohol use and family alcoholism. The lesson plans build on previous learning experiences and can be used over an 8- or 12-week period.

For further information on the curriculum, which costs $40 plus $4 shipping, contact Barbara Ford, AETC, 520 Main St., Waltham, MA 02154.

meetings

SEPTEMBER

Sept. 9-10. Chicago, IL. Management Seminars for Alcoholism Program Administrators. Contact Kim Hilberg, Program Coordinator, National Association of Alcoholism Treatment Programs, Inc., 1300 Bristol St. N., Newport Beach, CA 92660.

Sept. 13-17. Brooklyn Park, MN. Evaluating Alcohol and Drug Programs. Contact Leslie Nyberg, Evaluation and Research Department, Box 11, Center City, MN 55012.

Sept. 13-30. Minneapolis, MN. Training School on Alcohol and Drug Abuse. Contact Betty Reynolds, Johnson Institute, 10700 Olson Memorial Hwy., Minneapolis, MN 55441-6199.

Sept. 17-18. Milwaukee, WI. Issues in Human Sexuality for AODA Counselors. Contact Dorothy Dow, Coordinator of Training, DePaul Rehabilitation Hospital, 4143 South 13th St., Milwaukee, WI 53221.

September 20-22. San Diego, CA. Alcoholism Treatment: Cooperation or Competition. Contact Nomi Feldman, Conference Coordinator, 3770 Tansy, San Diego, CA 92121.

Sept. 20-22. Washington, DC. Case Management Training. Contact Fay Trice, Washington Area Council on Alcohol and Drug Abuse, 1221 Massachusetts Ave., NW, Washington, DC 20005.

Sept. 20-24. Minneapolis, MN. Intervention Skill Building Workshop. Contact Jan Winsand, Johnson Institute, 10700 Olson Memorial Hwy., Minneapolis, MN 55441-6199.

Sept. 20-24. Minneapolis, MN. Intervention Skill Development. Contact Johnson Institute, 10700 Olson Memorial Hwy., Minneapolis, MN 55441-6199.

Sept. 20-24. Pacific Grove, CA. Seventh Annual California Alcohol Conference. Contact Joan Mortensen, Alcohol Program Administrator, Monterey County Health Department, 1200 Aguajito Rd., Monterey, CA 93940.

Sept. 26-Oct. 1. Minneapolis, MN. Alcohol and Drugs: Working With Adolescents and Schools. Contact Community Intervention Inc., 220 South 10th St., Minneapolis, MN 55403.

OCTOBER

Oct. 3-8. Minneapolis, MN. Chemical Dependency and Adolescents. Contact Johnson Institute, 10700 Olson Memorial Hwy., Minneapolis, MN 55441-6199.

Oct. 4-22. Baton Rouge, LA. Three-Week School on Addiction Studies. Contact Duncan Rose, Training Director, Baton Rouge Chemical Dependency Units, Inc., 3968 North Blvd., P.O. Box 4109, Baton Rouge, LA 70821.

Oct. 6 - Nov. 10 (Wednesdays). Milwaukee, WI. Advanced Counseling Skills. Contact Dorothy Dow, Coordinator of Training, De Paul Rehabilitation Hospital, 4143 S. 13th St., Milwaukee, WI 53221.

Oct. 7-9. Alburquerque, NM. Fifth Annual Institute on Women and Chemical Dependency. Contact National Council on Alcoholism — Alburquerque Area Inc., Schick Shadel Hospital, Houston, TX 77027.

Oct. 8-9. Milwaukee, WI. Women, Alcohol, Drugs, and Sexuality. Contact Dorothy Dow, Coordinator of Training, De Paul Rehabilitation Hospital, 4143 S. 13th St., Milwaukee, WI 53221.

Oct. 8-9. Milwaukee, WI. Changing Roles for Men in the 80s. Contact Dorothy Dow, Coordinator of Training, De Paul Rehabilitation Hospital, 4143 S. 13th St., Milwaukee, WI 53221.

Oct. 9-10. San Francisco, CA. The Benzodiazepines Today: Two Decades of Research and Clinical Experience. Contact Stephanie Ross, Haight-Ashbury Training and Education Project, 409 Clayton St., San Francisco, CA 94117.

Oct. 11-13. Harbor Springs, MI. 15th Annual Michigan Alcohol and Addiction Association Fall Conference: Addictions (Awareness, Assessment, and Action). Contact Sally Myers, Administrative Assistant, MAAA, 29563 Northwestern Hwy., Suite 7, Bldg. F., Southfield, MI 48034.

Oct. 11-15. Minneapolis, MN. Support Group Facilitator Training Workshop. Contact Jan Winsand, Johnson Institute, 10700 Olson Memorial Hwy., Minneapolis, MN 55441-6199.

We Don't Want To Lose You

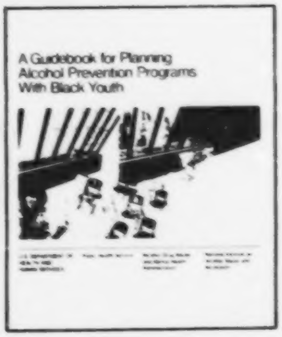
In order to continue receiving the *NIAAA Information and Feature Service*, all readers must complete the Circularization Form on pages 7-8 of the July 30, 1982, issue. Please complete the form and mail it to Dept. IFS, National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852. Forms *must* be received by Sept. 30, 1982. Thank you.

NIAAA Information and Feature Service (IFS) is a service of the National Institute on Alcohol Abuse and Alcoholism. The opinions expressed in the articles do not necessarily reflect the view of NIAAA.

IFS is produced by the National Clearinghouse for Alcohol Information of NIAAA. Correspondence should be addressed to Editor, IFS, NCALI, P.O. Box 2345, Rockville, MD 20852.

Editor: John Small
Art Editor: Julie Kurz

Black Americans Guidebook Now Available


A Guidebook for Planning Alcohol Prevention Programs With Black Youth

A Guidebook For Planning Alcohol Prevention Programs With Black Youth contains a wide range of ideas on starting programs to prevent alcohol problems among black youth. The 200-page manual describes the steps involved in starting a prevention program, including mobilizing interested groups, getting multiple agency support through networking, determining the issues that are of greatest concern to a community, writing a grant proposal, and holding a prevention workshop. It also describes the critical process of involving youth as partners in the program and looks at the culture-specific needs of minority communities. The *Guidebook* has three appendices that contain program planning materials, community workshop materials, and a glossary and references.

The *Guidebook*, developed by NIAAA's National Clearinghouse for Alcohol Information (NCALI), is the outgrowth of several years of interaction with community and church groups, State and local alcohol treatment and prevention groups, and black youth. This has included conferences in three sites to identify community needs and resources and to discuss strategies for setting up primary prevention programs aimed at black youth.

The *Guidebook* is designed to serve as a reference publication for alcohol prevention programs that work with black youth; an effective tool for involving black church groups in alcohol problem prevention; and a resource for a wide range of existing community groups involved in working with black youth. A limited number of single copies of the *Guidebook* (order no. BK91) are available at no charge from the National Clearinghouse for Alcohol Information, Box 2345, Rockville, MD 20852.

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NIAAA Information and Feature Service

August 30, 1982

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Conference Sessions Address Nurses' Role in Treatment

As the treatment setting for the alcoholic patient becomes increasingly varied—ranging from hospital inpatient settings to freestanding alcoholism treatment centers to outpatient settings—the role of the nurse in alcoholism treatment also becomes more varied. To be effective in a range of contexts, today's nurse plays a variety of roles: medical technician, teacher, counselor and group facilitator, patient advocate, community liaison, and alcohol specialist.

Several perspectives on these changing roles of nurses were presented at the National Nurses Society on Alcoholism meetings during the National Council on Alcoholism (NCA) Forum held in Washington, DC.

In discussing the multiple roles of a nurse in a comprehensive level of care system for alcoholic patients, Phyllis A. Solari-Twadell of the Lutheran Center for Substance Abuse in Park Ridge (IL) suggested that the alcoholic patient's needs must be accurately assessed and matched with resources that will give the treatment needed in a cost-effective manner. For example, she said, the comprehensive level of care system at Lutheran General Medical Center includes a general hospital, a specialty hospital, residential rehabilitation, adult and youth independent living, and a primary outpatient program (adult and youth). Each provides a different service designed to meet specific needs, she said.

Just as treatment resources must be matched to client needs, she said, nurses' skills must also be matched to patient needs. The intensive psychiatric and medical-surgical level of care in the general hospital requires nurses to perform a wide range of activities, she said. In addition, a healthy attitude and knowledge of alcoholism treatment is essential. Nurses must be medical technicians with teaching skills that can fit into a psychosocial/medical context, and they must also be able to assist other staff members in identifying and understanding alcoholism and the alcoholic patient and to help motivate the patient to enter the next needed level of care.

The specialty hospital provides detoxification, assessment, evaluation, and concurrent treatment for alcoholism and medical/psychiatric conditions. This level of care emphasizes the teaching role of the nurse. Nurses in this level of care need very effective communication, interviewing, teaching, and counseling skills.

By contrast, the nurse in the residential rehabilitation setting should feel comfortable working alone since there frequently is only one nurse on duty per shift. According to Solari-Twadell, the role of this nurse is primarily one of being able to respond to any medical or psychological emergency that emerges. The nurses in extended care and outpatient settings have to expand their counseling, evaluation, and interviewing skills, she added.

Solari-Twadell suggested that nurses in each of the settings must be able to assess their own position, determine what skills and information are needed to care for the alcoholic patient effectively, and obtain additional training.

In another session, Britt Finley, associate professor, Montana State University School of Nursing, explored the role of the alcohol-specialist nurse in developing a prevention program in a rural setting. This role requires not only a specialty in alcoholism, but also an expanded understanding of the basic tenets of nursing, she said. In the role of "prevention worker," the nurse must work with families. The nurse also must understand education, community, and institutional programs, and must be capable of analyzing factors "that impact on health at the family and community levels." The nurse also needs group skills, teaching expertise, interagency awareness, and a keen understanding of alcohol dependence. Because prevention funds are often secured from local, State, or National sources, Finley suggested that political wisdom would increase the competency of an alcohol prevention worker, she said.

For further information, contact Phyllis Ann Solari-Twadell, R.N., B.S.N., M.P.A., Director of Nursing Services, Lutheran Center for Substance Abuse, 1700 Luther Lane, Park Ridge, IL 60068; or Britt Finley, B.S.N., M.E., Associate Professor, School of Nursing, Montana State University, Missoula, MT 59812.

—Millree Williams

Special Report on Alcoholism Treatment for Women

This issue of the *NIAAA Information and Feature Service* contains a 4-page Special Report on *Advances in Alcoholism Treatment Services for Women*, a forthcoming publication detailing the proceedings of the Women's Alcoholism Treatment Service Conference, sponsored last December by NIAAA.

The conference brought together representatives of 40 NIAAA-funded women's treatment programs and was designed as a forum for the sharing of information about women's alcoholism treatment needs. Because the participating programs hailed from every region of the country and represented urban, rural, and suburban populations, their discussions reflect a myriad of experience in dealing with alcoholic women.

Advances in Alcoholism Treatment Services for Women brings together the proceedings of this conference. Issues discussed include effective outreach strategies; treatment approaches; aftercare; community linkages, fundraising, marketing, and legislation; research and evaluation; and conference conclusions.

The Special Report on *Advances in Alcoholism Treatment Services for Women* is presented on pages 2-5 of this issue of the *NIAAA Information and Feature Service*.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • PUBLIC HEALTH SERVICE • ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

HE 20.8312:

Publication Focuses on Women's Treatment Issues

Special report prepared by Jill Vejnoska, NCALI Staff Writer

Introduction

Later this year, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) will publish *Advances in Alcoholism Treatment Services for Women*, a publication detailing the proceedings of the Women's Alcoholism Treatment Service Conference sponsored by NIAAA last December in Minneapolis (MN). The conference, which brought together representatives from 40 of 45 NIAAA-funded women's treatment and occupational programs, was designed to encourage sharing of information about women's alcoholism treatment needs. The participants shared their experiences in providing alcoholism treatment services to women over the past 10 years, and those presentations and discussions are contained in the publication.

The conference was designed, according to NIAAA Project Officer Margaret Wilmore, to "capture significant issues and practices of women's programs," and thus to create a network of information and research exchange among persons associated with women's alcohol programs. Because the participating programs hailed from every region of the country and represented rural, urban, and suburban populations, their recommendations reflect a myriad of experience in dealing with alcoholic women.

Speaking last spring at the annual Forum of the National Council on Alcoholism (NCA), Lois Chatham, Ph.D., NIAAA's Acting Director of Extramural Research, described the Institute's longstanding commitment to improving services for women and its past efforts to gather information in this area. "NIAAA experimented in funding women-specific programs to see if women recover faster in female-administered and/or -oriented programs," Chatham said. She cautioned that neither the workshop nor the findings are intended to speak for all women's programs, but said that the proceedings would add to what is known about the female alcoholic and would suggest areas for future research. "For the most part, these are not yet scientific findings," Chatham emphasized. "We hope that will be the next step."

The "next step" is, in fact, already in place. *Advances in Alcoholism Treatment Services for Women* concludes with "Questions Raised by Participants for Future Research," a section highlighting potential subjects for further study, including casefinding, treatment, aftercare, and subpopulations. Preceding this are sections reflecting the detailed discussions held by participants about a number of subjects affecting treatment of women alcoholics; these include outreach, treatment modalities, aftercare, the community, and research and evaluation. The remainder of this article recounts some of the more significant findings that emerged from the conference and that appear in the monograph.

Outreach

According to conference participants, because "social and cultural mores" about alcoholism and alcohol use, aggravated by a "double standard based upon sex," exist, "identifying and reaching out to women alcohol abusers poses a fundamental challenge to women's treatment and occupational programs." The publication's authors caution that few programs have adequate staff or money resources to measure the effect of particular outreach strategies, and say that most programs have had to adopt a "trial and error" approach to outreach. Some strategies that participants indicated have proved effective are:

- Learning about the client population, developing the program philosophy, and identifying individuals and agencies in the community who can assist in outreach.
- Encouraging program staff to work with staff of other community agencies.
- Other, indirect approaches such as raising community awareness of, while dispelling myths about, female alcoholics; training professionals in other fields to recognize alcoholism in women; and educating management and employers about potential alcohol problems in the workplace.

More specifically, participants agreed that — in general — outreach is more successful among women when it is conducted by women, who are, ideally, of the same ethnic background as the population with which they are working. If this ethnic "match" is not possible, they continued, then the outreach worker should be aware of and sensitive to the needs of that particular group. By way of example, the monograph cites Native American communities which are, on the whole, mistrusting of outreach workers who do not attend social functions on the reservation. However, an exception to the same sex rule is found when working in Hispanic communities where the initial contact is usually made by and through males. In this culture, the male plays a key role in assisting women to enter treatment.

Advances in Alcoholism Treatment Services for Women also offers insight into working with the media, a skill many participants claimed would increase the effectiveness of outreach efforts. One participant reported that television coverage of her program resulted in a 33 percent increase in crisis calls. In the area of education, participants indicated that "breaking through community denial" is the most vital issue faced by organizers of women's programs. They recommended involving community group members in the treatment center from its inception. Having staff lecture on women's health issues at civic, religious, and social functions was seen as a means of reducing community denial of alcoholism among women. In addition, they emphasized the importance of adapting educational techniques to the needs of special subpopulations, such as blacks, Native Americans, Hispanics, lesbians, the elderly, and working women.

Treatment

The workshop participants also discussed treatment approaches, with the majority agreeing that separate women's programming, usually that which emphasizes holistic techniques, is essential in helping women recover from alcoholism. Alcoholic women usually suffer from low self-esteem and problems of dependency, they said, and single-sex, supportive groups are the best forums for addressing such problems. Likewise, they asserted, in general, treatment personnel who are female, of like ethnic background as the populations they are serving, are the most effective guides and role models for alcoholic women. The monograph's authors write, "too often, women with alcohol problems have had few individuals in their lives who exemplify a sober, constructive adult lifestyle. Therefore, over and beyond providing treatment for clients, staff in alcoholism programs serve a variety of covert functions that affect a woman's road to recovery." In addition, they say, it is essential that alcoholic women develop outside support systems. Such groups aid recovery by providing peer counselors and role models for alcoholic women. Alcoholics Anonymous (AA) was cited often as an example of a strong support group, but many workshop participants also emphasized the importance of adapting the AA program to the needs of Native Americans, blacks, and Hispanics, and of using other groups such as Women for Sobriety (WFS).

Equally important is the attention to the physical well-being of female clients, participants said. Therefore, in a section on prevention and holistic health, the monograph's authors emphasize the importance of complete, regular physical examinations and of good nutrition to an alcoholic woman's recovery. In addition, participants suggested teaching clients to identify sources of stress — occupational, environmental, personal, and interpersonal — in their lives, and methods — regular exercise, yoga, and meditation — for combating them.

Other issues related to self-esteem and dependency that are discussed in the publication include vocational development, child care, and relationships. An alcoholic woman's relationships with others are usually poor or confused. Workshop participants stressed that female clients should learn to "untangle" issues of intimacy, develop nonsexual friendships, and improve their communication skills, especially with family members. As one aspect of this developmental process, participants suggested teaching clients assertiveness skills so that they can verbalize their needs and desires, seek out needed social services, and accept themselves as separate, autonomous persons. Learning to become more assertive is especially important for women who have been or who are victims of sexual abuse.

According to the publication, workshop participants agreed that alcoholic women need help on improving life management skills in general. "Because self-esteem is an overriding issue in women's treatment, any changes occurring for an alcoholic woman that make her feel better about herself and increase her self-confidence are linked to her emotional well-being," they concluded.

Aftercare

Aftercare was seen by workshop participants as being essential to a woman's recovery from alcoholism, but not without potential problems. According to *Advances in Alcoholism Treatment Services for Women*, aftercare was conceptualized by participants as a critically needed reinforcement process for gains made in treatment — gains, which for the woman client, are likely to conflict with role expectations in the home, community, and employment setting.

Particularly crucial to aftercare, the participants felt, is maintaining contact with clients during the difficult period after treatment ends, when their changed attitudes toward themselves may breed uneasiness in family, friends, and employees, and when they may encounter pressures to return to the drinking environment. At the same time, the professionals warned against maintaining too close ties with clients, and thereby jeopardizing the independence they have worked so hard to develop while in treatment. "In summary," say the authors of the publication, "obstacles to aftercare programs for women appear once again to be related to the specific sociocultural issues faced by women. Women, by and large, do not have access to sensitive support systems to replace the support provided by the treatment center." It is the treatment program's responsibility to provide this continuous support, contended participants, who developed the following set of aftercare goals:

- *Providing support for life management problems and sobriety* by encouraging attendance by clients and staff at AA or WFS meetings; supporting job-hunting activities with resources, information, practice testing, and help with resume writing; reducing transportation and housing problems; combating family violence and communication problems; and helping clients obtain good medical care.
- *Reinforcing and continuing progress made in treatment* by providing and encouraging participation in group therapy, concerned persons support groups, and family and individual counseling. The areas most often needing reinforcement are assertiveness, stress management, vocational development, sexuality, grief therapy, and communications skills.
- *Providing sober social functions* for recovering women and their families, and encouraging clients to use the facility as a "drop in" center when they have completed treatment. In addition, some participants suggested sponsoring annual dinners for former clients and the outside community.
- *Maintaining contact in the event of a crisis* by initiating regular contact with former clients through newsletters and followup questionnaires. Some programs address aftercare at the time a woman is admitted, while others gradually introduce clients to aftercare by discussing discharge practices, relapse, and reentry procedures before treatment is completed.

The Community

Most of the programs represented at the conference have experienced some reduction in funding. While participants saw program survival linked to State and local support — raised through fundraising, legislation, advocacy, marketing, and lobbying — they noted that certain strategies among members of the general community can help them gain this support.

Issues related to gaining support include:

- Becoming familiar with the State political structure (particularly State Alcoholism Authorities) and joining with other human service groups to lobby for funds. Too often, participants explained, an attitude predominates that women's programs have poor prognoses for success and that they are taking money away from other, more successful programs. Working with other lobbying groups, coming under the aegis of an umbrella agency, or meeting directly with legislators can help build support for women's alcohol programs, participants maintained.

- Developing a strong advisory board or board of directors to raise community awareness about female alcoholics. Workshop participants recommended inviting highly visible, well-respected members of the community to serve on advisory boards; other professionals suggested selecting persons with special skills — i.e., fundraising or access to needed services — for advisory positions.

- Seeking help from universities — that is, utilizing their fundraising techniques or networks, and encouraging students to work for programs on a volunteer or for-academic-credit-basis. This approach, like those mentioned above, educates and informs different members of the community about female alcoholics, and thereby improves the program's standing in the community, participants said.

According to *Advances in Alcoholism Treatment Services for Women*, workshop participants felt that there are some community attitudes that must be addressed continually, including: the stigma sometimes attached to cross-addicted women in AA meetings; the rejection of alcoholic women by some vocational rehabilitation staff; the lack of acceptance of alcoholism as a women's issue by some women's groups; the reluctance of some alcoholism professionals to view women's alcoholism issues as different from those of men; the images and stereotypes associated with minority alcoholics; the barriers against lesbian programs; the negative attitudes of some teachers toward children of women in treatment; the attitudes and practices of physicians toward their clients that may lead to inappropriate prescriptions for drugs; the reluctance of many public officials to make driving while intoxicated (DWI) referrals to women's programs, particularly in the case of upper-middle-class and older women; and the negative attitudes that women alcoholics sometimes encounter on the part of staff in detoxification centers.

The participants recommended employing a quiet, low-key, activities-oriented approach that expands community awareness of, and reduces anxieties about, alcoholism among women. Possible strategies might include interweaving program and community interests; discussing female alcoholism and the need for a treatment center with local residents before locating within their community; and making connections with AA in the community. Adding that these theories also work in practice, participants said that they had seen attitudinal changes in their communities, and, the publication continues, they "also felt that they had reduced family violence and sexual abuse, drinking patterns and norms, and have helped keep families together."

Research & Evaluation

One workgroup at the Minneapolis conference focused on research and evaluation. Participants distinguished between evaluation research and management information systems, described program evaluation research conducted in women's programs, and shared working knowledge about outcome measures and clinical assessments of client success. Additionally, they formed workgroups in order to generate a range of possible outcome effectiveness criteria that might be valuable to women's treatment programs.

Thomasina Borkman, Ph.D., associate professor of sociology at George Mason University, chaired a discussion of program evaluation research. In what she termed a paradox, Borkman said, "You as program people cannot do evaluation research without special research training, but evaluation research cannot be done without you." To discuss this research dilemma, Borkman introduced two program directors who are involved in different types of evaluation. Ruth Little, Sc.D., who directs a pregnancy and health program in Seattle (WA), discussed her unique status as a researcher who "happens to be the program director of treatment operation." Paula Roth, of the Skyward program in Rockland (ME), noted that, while she is not a researcher, she is "a program person with a strong clinical and administrative background," who also must conduct program evaluations. Little's and Roth's different experiences with program evaluation research are described in full in *Advances in Alcoholism Treatment Services for Women*.

In order to conduct effective evaluations, Borkman said, program managers need to involve staff in the planning and in the development of instruments to carry out such research. Doing so will help women's programs realize their goal of creating a mutually supportive relationship between researchers and treatment staff. "Program people have intuitive and informal yardsticks or criteria by which they judge changes made in clients," Borkman said. "Researchers formalize their intuitions and thus help program people to specify the criteria and measuring instruments to be used."

The second part of the research and evaluation sessions consisted of small group discussions to elicit client outcome criteria used in the women's programs. These were designed to find out what participants use (either implicitly or explicitly), or would like to use, as criteria for determining measures of successful treatment outcomes.

Conclusions

Finally, an integrative summary identifies two themes repeatedly expressed by participants in the Minnesota conference: that women's programming should be holistic in focus; and that women's concerns, which reflect problems faced by women in day-to-day life, are magnified by alcohol use and therefore significantly affect all program activities. Based on the various discussions of alcoholism programming for women, participants concluded that:

- Outreach activities cannot be limited to casefinding.
- Treatment activities cannot be limited to recovery from alcoholism and other traditional concerns; rather that "behavioral repertoires" of clients must be broadened and self-esteem levels raised.
- Aftercare goes beyond the concept of merely providing ongoing support for gains made in treatment.
- Community involvement has broader implications for women's programming than had previously been thought, with potential for increasing credibility, reducing fears and myths about female alcoholism, and bolstering fundraising and marketing activities existing in that arena.
- A range of issues must be considered in research and evaluation; all of these areas, including abstinence, outreach, treatment, aftercare, community involvement, and research and evaluation, are interrelated and must be dealt with as a continuum by program staff.

Finally, *Advances in Alcoholism Treatment Service for Women* asserts that women's treatment represents a "delicate balance" in that:

- In order to get women to enter the programs, staff must significantly change public attitudes toward women and women alcoholics. Yet, staff must be sufficiently identified with the local cultural norms so that they gain the trust and respect needed to become accepted as a viable organization in the community.
- In order to effect healthy sobriety and create a more androgynous repertoire of behaviors, staff must encourage the broadening of their clients' lifestyle perspectives. Although this is perceived by staff to be important for the women's recovery, it sometimes causes the client and those near to her to experience considerable fear and anxiety.
- High achievement may arouse fear and rejection of the client's role as a woman; acceptance as a woman sometimes requires foregoing personal goals of achievement.

The monograph's authors suggest that the programs represented at the Minneapolis conference have, on the whole, been successful at maintaining this balance because their staffs are more attuned to women's needs and to the complicated situations female alcoholics face. In addition, program directors have insisted that both they and their staffs be trained in meeting these needs, a fact that, the monograph asserts, increases the effectiveness of their treatment programs.

Other sections of the publication include a "Research Observor's Report," in which comparisons are made between research findings on women and experiential information provided by conference participants; a "Project Directory," detailing residential, outpatient, comprehensive, and occupational services available for women; a "Review of the Research Literature on Women and Alcohol"; and minutes from a forum on the National Women's Congress on Alcohol and Drug Problems.

Advances in Alcoholism Treatment Services for Women is expected to be published later this year. Ordering information will be reported in an upcoming issue of the *NIAAA Information and Feature Service.*

Special Report ☐

Family Systems Theory Explored at Conference

Family systems theory has direct applications in the treatment of alcoholism and other drug abuse, according to Murray Bowen, M.D., director of the Georgetown University Family Center. At a recent conference at Georgetown University in Washington (DC) on "Understanding Family Systems with Alcoholism and Drug Dependency," several hundred participants explored the role of the family in addiction, treatment, and recovery. Bowen urged counselors to investigate the family history of the alcohol-abusing family member rather than looking for a "cookbook" way to stop the drinking. He said that alcoholism can be influenced by psychological, sociological, and biological paradigms and that treatment based on any single approach is insufficient. A family systems approach, he said, cuts across all three areas of inquiry.

"Systems theory assumes that all important people in the family unit play a part in the way family members function in relation to each other and in the way the symptom finally erupts," he said. "The symptom of excessive drinking occurs when family anxiety is high. The process of drinking to relieve anxiety, and the increased family anxiety in response to drinking, can spiral into a functional collapse or the process can become a chronic pattern."

Bowen urged counselors to move the focus of therapy away from just stopping the drinking, to focus on the family system as well. "Family systems therapy offers no magic solution for the total program," he said, "but the theory provides a different way to conceptualize the problem, and the therapy provides a number of approaches that are not available with conventional theory and therapy. From a systems viewpoint, therapy is directed at helping the family to modify its patterns of functioning."

Several other speakers urged that, in families where the alcoholic refuses to enter therapy, counselors work with the family member who shows the most potential for change. When this person begins to change, Bowen said, there will be change throughout the family system and, often, a decrease in alcoholic drinking.

"The therapy is directed at the family member, or members, with the most resourcefulness, who has the most potential for modifying his or her own functioning," Bowen said.

For further information, contact Marjorie Hottel, Georgetown University Family Center, 4380 MacArthur Blvd. NW., Washington, DC 20007.

—John Small

FACTS FOR PLANNING:
YOUTH AND ALCOHOL

As all planners and policymakers know, the ability to understand research findings is one thing; the ability to make them work for you is quite another. That is why the *Facts for Planning* series can be of special value to those committed to reducing alcohol problems among youth.

Using non technical language, this series of concise reports presents major research findings from the Research Triangle Institute's 1978 probability survey on the extent and nature of alcohol use among the Nation's senior high school students (10th to 12th grades) and explores the implications of these findings for the development of alcohol programs and policies for youth.

Designed to be used singly or in combinations, the reports are of central interest to educators, community organizers, State and local administrators, prevention and other health planners, and counselors concerned with youth. They cover such topics as:

- Extent of alcohol use
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- Parental influence on alcohol use.

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- Facts for training educators, counselors, and parents about the dimensions and nature of student alcohol use
- Facts for community organizing that can be used to show the need for interagency cooperation, to mobilize volunteers, and to raise funds or write grant applications
- Facts for prevention planning that can be used in the preparation of State Plans or legislative studies, in the design of State and community surveys, or in assessments of the extent of alcohol use among local youth
- Facts for program planning that can be used to estimate the number and characteristics of youth at high risk for alcohol abuse and the types and number of staff needed to serve them.

Single, free reprints of the reports, first published in NIAAA's quarterly magazine *Alcohol Health and Research World*, are available upon request.

Send completed form to: NIAAA National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852.

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RPO385 ________**Facts for Planning** No. 5. Adolescent marijuana and alcohol use. *Alcohol Health and Research World* 6(3):69-75, 1982

RPO386 ________**Facts for Planning** No. 6. Parental dimensions in teenage drinking. *Alcohol Health and Research World* 6(4):58-63, 1982.

NIAAA Information and Feature Service September 29, 1982

NIAAA Magazine Focuses on Drunk Driving

Drunk driving. It's a factor in as many as 25,000 deaths and 75,000 injuries each year in the U.S. And it is one of the leading causes of death among this Nation's young people.

It's not a new problem. But the tragic consequences of drunk driving have mobilized a wide range of groups and individuals to seek new solutions in recent years. In communities across the Nation, police have stepped up DWI enforcement efforts, lawmakers have enacted stringent penalties for drunk driving offenders, and citizen activist groups have banded together to seek out new approaches to keeping drunk drivers off the highways.

The Fall 1982 issue of *Alcohol Health and Research World*, the quarterly magazine of the National Institute on Alcohol Abuse and Alcoholism, is almost entirely devoted to the topic of drinking and driving, including:

- The creative approaches to reducing the problems that have been developed by citizen activists — often relatives of victims of drunk driving accidents or parents concerned for the safety of their children
- The legislative approaches under consideration or recently enacted in many States — new laws that mandate stringent minimum penalties for drunk driving offenders, that raise the minimum drinking age, and that support more intensive enforcement of drunk driving laws
- Four very different, but promising, approaches to preventing drunk driving tragedies among young people
- Federal efforts to address the drunk driving problem, including the appointment last spring of the Presidential Commission on Drunk Driving and new initiatives recently launched by the National Highway Traffic Safety Administration
- A research-based perspective on what measures have been tried in the past to reduce drunk driving and how effective they have been, as well as on what measures might be tried in the future and an assessment of their potential for combating the drunk driving problem
- An indepth review of the Scandinavian model — often portrayed as the most effective approach to reducing drunk driving — and a well-documented discussion of how effective deterrence measures in the Scandinavian countries have been in actually reducing drunk driving
- The extent to which alcoholics are involved in drunk driving incidents, and approaches that have incorporated rehabilitation of the problem drinker into efforts to reduce repeat offenses by those convicted of drunk driving
- The opinions of leading traffic safety and alcohol-related groups on how best to reduce drunk driving, and highlights of current efforts by voluntary and private sector organizations to address the problem
- A resource listing — names and addresses of people you can contact for further information, materials, and ideas.

If you are concerned about drunk driving . . . if you are seeking to understand the complexities of the problem and identify realistic approaches to reducing drunk driving . . . you will find *Alcohol Health and Research World* a valuable resource.

There is no simple solution. But progress is being made in finding and applying solutions. *Alcohol Health and Research World's* Fall 1982 issue can point you in the right direction, giving you the facts and the contacts to understand the problem, identify the alternatives, and get in touch with others who are working to solve it.

Thousands of counselors, researchers, and others interested in alcohol topics consider *Alcohol Health and Research World* "must" reading.

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Alcohol Health and Research World is available only by subscription, for the low rate of $11.00 a year ($13.75 to foreign addresses). To subscribe, send a check, money order, or credit card authorization (include name, VISA or Mastercard number, and expiration date) to Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

meetings

Oct. 11-13. Washington, DC. Advanced Interviewing Techniques. Contact Fay Trice, Washington Area Council on Alcohol and Drug Abuse, 1221 Massachusetts Ave., NW, Washington, DC 20005.

Oct. 11-15. Minneapolis, MN. Group Seminar on Adolescence and Chemical Abuse. Contact Johnson Institute, 10700 Olson Memorial Hwy., Minneapolis, MN 5544-6199.

Oct. 12-16. Washington, DC. Families and Government. Contact Sue Anne Williams, National Council on Family Relations, 1219 University Ave., SE., Minneapolis, MN 55414.

Oct. 13-14. Dublin, Ireland. The Effects of Alcoholism in Industry. Contact Jeanne McNamara, Registrar, Maurice Quinlan and Associates, 36 Tirconnell Avenue, Lismore Lawn, Waterford, Eire, 051-55733.

Oct. 14-15. Fort Worth, TX. Conference on Alcoholism Treatment Evaluation: Issues and Applications. Contact Wendy Lipton, Conference Coordinator, Center for Organizational Research and Evaluation Studies, Texas Christian University, P.O. Box 32874, Fort Worth, TX 76129.

Oct. 15-16 and 29-30. Milwaukee, WI. Advanced Counseling Skills. Contact Dorothy Dow, Coordinator of Training, De Paul Rehabilitation Hospital, 4143 S. 13th St., Milwaukee, WI 53221.

Oct. 30. Newark, NJ. Third Annual Conference on Alcoholism in the Black Community. Contact Cody Barrett, ABC c/o RAFT, East Orange General Hospital, 300 Central Ave., East Orange, NJ 07019.

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From the National Clearinghouse for Alcohol Information of the National Institute on Alcohol Abuse and Alcoholism

Prevention Program Aimed at Young Drinking Drivers

It is rare that the Shock Trauma Center at the Maryland Institute for Emergency Medical Services Systems (MIEMSS) in Baltimore is visited by conscious, walking teenagers. Some 30 percent of MIEMSS patients are youth in the 11- to 20-year-old range, and the majority (20 percent) are brought to this multiple trauma unit with life-threatening injuries incurred in traffic accidents. More sobering still is this statistic: 67 percent of all young people treated at MIEMSS have been involved in alcohol- or drug-related traffic accidents.

In an effort to prevent at-risk teenagers from becoming part of these statistics, the MIEMSS nursing staff developed the Adolescent Trauma Prevention Program. Identified substance-abusing youth are introduced to the Shock Trauma Center in general, and in particular, to young patients who have suffered multiple trauma as a result of alcohol- or drug-related traffic accidents.

Nurse coordinator Beverly Dearing, R.N., M.S., said that the program evolved "after a group of nurses at MIEMSS discussed their concerns that an increasing number of young people, aged 15 to 25, were being admitted to the Shock Trauma Center with multiple injuries due to highway accidents and that over 90 percent of these accidents (in this age group) were associated with alcohol (the patient either had a high blood alcohol level or was the innocent victim of an intoxicated driver)." The nurses recognized the significant costs of these accidents to both victims and their families. "In many cases, injuries were extensive and resulted in permanent disability or loss of the patient's most productive years," Dearing explained. "In addition, severe trauma usually altered the family structure, creating severe emotional stress, and in many cases, created an economic burden for the family and for society."

The MIEMSS nursing staff, in cooperation with the Juvenile Services Division of nearby Anne Arundel County's Department of Social Services, developed an educational program for adolescents that focused on the relationship between alcohol and drug use and traffic accidents. A large percentage of MIEMSS youthful patients came from Anne Arundel County, where juvenile officials were concerned about the number of adolescents being referred to their agency for abusing alcohol or drugs while driving. According to Dearing, the MIEMSS nurses and the juvenile services administrators established the following goals for the 1-day program: to communicate the purpose of MIEMSS and the Shock Trauma Center to teens; to help them identify the potential consequences of drunk driving; and to help them recognize their own potential as accident victims. "It was hoped that viewing the real consequences of what could happen if one mixed driving with alcohol or drugs would have a considerable impact on adolescents who characteristically feel that they are indestructible," she said.

Adolescents who participate in the program are Anne Arundel County residents, aged 15 to 18, who have been charged with possession of alcohol or drugs or who have committed motor vehicle offenses related to use of these substances. Often, a judge has recommended that a youngster attend the Trauma Prevention Program; however, participation is voluntary.

During the program, the MIEMSS nurses and the Juvenile Services administrators lead the teens in discussions of the social pressures to drink and drive, and the possible consequences of and alternatives to such behavior. "We knew from the outset that the *worst* thing we could do would be to lecture to these kids," Dearing said. The only thing faintly resembling a lecture is the program's alcohol education component, which Juvenile Services personnel provide on the van ride to MIEMSS and later at a followup session. Even then, Dearing emphasized, the sessions are informative rather than didactic. In addition to education, the program includes a description of the Shock Trauma Center; presentation of a videotape on the center; a 30-minute tour of the trauma center; a discussion with a former trauma unit patient on many different aspects of the drunk driving issue; and a discussion and problem-solving session at which participants continue to examine their own drinking and driving and attempt to formulate alternative forms of behavior.

On the tour, the teenagers follow a hypothetical patient through the trauma center. In the intensive care unit, the nurse steers the tour toward preselected critically injured patients. This ensures that the patients' anonymity will be protected — names, charts, and revealing features are covered up, Dearing said.

Juvenile Services personnel administer a questionnaire to teens at the end of the tour. In addition, a followup study is done 6 months later. Thus far, response to the program has been overwhelmingly favorable. Data collected on 95 of the 135 youth who participated in the program from January 1979 through May 1981 reveal that 48.5 percent rated the program "excellent," 47.5 percent "good," and 4 percent "fair." When asked to respond to the impact of the program on their current behavior problems involving alcohol or drugs and driving, 79 percent responded that the program would probably have a positive effect; 2 percent thought it would have no effect; and 19 percent felt it might have an effect of some kind. Data on recidivism, though incomplete, seems to support these figures. In one followup study, data were gathered on the program's first 54 participants. Of these 54, only 3 were rearrested (6.4 percent), and only 1 was for a specific alcohol-related charge (driving while impaired). Another followup study of 41 participants, found that only 1 had been rearrested for a motor vehicle violation, and there was no indication that it was alcohol or drug related.

For further information on the Adolescent Trauma Prevention Program, contact Beverly Dearing, R.N., M.S., Nurse Coordinator, Maryland Institute for Emergency Medical Services Systems, 22 South Green St., Baltimore, MD 21201.

—Jill Vejnoska

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • PUBLIC HEALTH SERVICE • ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

HE 20.8312:

The EAP Concept at the Local Level

Editor's Note: In recent years, the Westchester (NY) Council on Alcoholism and the Westchester Department of Community Mental Health have worked together toward a common goal of reducing alcohol abuse and alcoholism in the community. A particularly effective example of this type of cooperation is occurring in the Westchester County school system where the employee assistance program (EAP) concept is being used in a variety of ways. The needs of alcohol-troubled administrators, teachers, and staff are being addressed by an employee assistance program that was designed specifically for the school system by the Westchester Council on Alcoholism. The needs of students — much different from the needs of employees — are being addressed by the Student Assistance Program, a prevention and early intervention program based on the EAP model and developed by the Westchester Department of Community Mental Health. The following two stories look at these programs in detail and at the comprehensive approach they take toward the prevention of alcohol and other problems.

EAP Assists School System Employees

Like businesses in the private sector, school systems are beginning to develop employee assistance programs (EAPs). One major difference, however, is that school systems must be responsive not only to school administrations and boards of education but also to local community standards. For school systems, this often means unique considerations that must be addressed in the implementation of an EAP.

These issues were discussed by Rita Brovarski, director of education and training for the Westchester Council on Alcoholism (WCA) in White Plains (NY), which — over the past 7 years — has assisted the Westchester County school systems in developing and maintaining an EAP for employees in 3 cities and 48 individual school districts. At present, 37 percent of the school system's employees (roughly 5,000 people) are served by the EAP.

According to Michael O'Brien, EAP consultant at WCA, a school system first contacted WCA in 1975 about the possibility of establishing an EAP. The WCA, a private, nonprofit affiliate of the National Council on Alcoholism (NCA), conducts a variety of counseling, education, and training programs and assists in the development of EAPs.

The two groups determined that a program could be set up at a cost of $10 per employee, to cover the cost of policy and procedure development, training for both an EAP committee and supervisory staff in the school system and an in-house coordinator to make referrals, to plan orientations for school staff members, and consultation and referral services. While WCA does not provide individual and group counseling services on an ongoing basis, it does the initial screening and referrals. Employees requiring more intensive treatment or detoxification are referred to other community resources. The in-house coordinator and the EAP consultant also examined various health insurance plans to determine which services would be reimbursable.

After the contract was signed, WCA assisted each school in establishing an EAP committee. These committees are made up of representatives from the school administration, various unions (teachers, secretarial, maintenance, transportation, and food service) and other interest groups within the organization. The EAP committees are responsible for monitoring the in-house program activities and for selecting the in-house coordinators who serve as the initial source of referral by employees.

According to Brovarski, in-house coordinators are intended to be individuals who are caring, compassionate, sensitive, respected by their peers, and comfortable with the subject of alcoholism. They spend an average of 2 half-days a week working on EAP activities and must be accessible to all employees. Several schools have selected the school nurse for this position, while other schools have filled the position with other qualified faculty or staff members.

Once selected, the in-house coordinators attend 3-day training sessions conducted by WCA. The sessions focus on a wide range of occupational issues, including basic elements of a program (development of policy and procedure), role of the coordinator, models for supervisory training, kinds of referrals, effects of alcoholism and other problems, personal effectiveness training, and development of practical skills necessary to administer the EAP program.

Prior to completion of this certificate program, each participant is required to develop a model for program implementation. The purpose is to have each trainee define the specific program goals and outline a time frame for their completion. The seminars, which last from 9 a.m. until 9 p.m. and are limited to 10 participants, also include experiential workshops designed to develop the individual's self-actualization potential.

According to a 5-year study recently completed by the WCA, the in-school coordinator system seems to be working. Preliminary analysis of the data showed that 88 percent of those served were self-referrals and 12 percent were referred by supervisors. Of the self-referrals, 63 percent contacted the in-house coordinator and 25 percent went directly to WCA for help. WCA's trained counselors work with those with alcohol and other problems and serve as a further referral source for those requiring more intensive or followup treatment. WCA also advises the EAP committee and provides materials on alcoholism and other serious problems affecting the workforce.

According to Gordon Bohl, counselor and trainer for WCA, 37 percent of the referrals from the school system to the program have been alcohol related. As is characteristic in a broad-based EAP, alcoholism is not always the problem identified by the troubled employee. However, alcohol problems may surface in later counseling sessions.

The EAP committees also prepare annual reports for the school administration and the board of education. All contacts and referrals, however, are held in strictest confidence by the in-house coordinators and the WCA.

For further information, contact Rita Brovarski, Westchester Council on Alcoholism, 10 Longview Ave., White Plains, NY 10601.

— Jim O'Hair

Student Assistance Program Based on EAP Model

A prevention and early intervention program based on the Employee Assistance Program (EAP) model has been helping to reduce drug- and alcohol-related behavioral problems among students in 19 Westchester County (NY) schools.

According to Program Director Ellen Morehouse, a significant number of students who exhibit troubled behavior in school—as manifested by truancy, lateness, disruptiveness, or poor academic performance—have problems with alcohol, or have parents who are alcoholics. A smaller, yet still important, percentage of these students are problem drinkers, with alcoholic parents as well. In a presentation at the National Institute on Alcohol Abuse and Alcoholism (NIAAA), Morehouse discussed the student assistance program, outlining its efforts to identify and counsel troubled students.

According to Morehouse, the student assistance program grew out of a 10-week counseling group for high school students with alcoholic parents that was begun in 1976 at the Westchester Department of Community Mental Health (DCMH). Counselors were so successful at helping teens better understand and cope with their parents' alcoholism and their own resultant feelings that the decision was made to form similar groups in the county's high schools. In July 1979, funding was received from the New York State Division of Alcoholism and Alcohol Abuse to operate the program in six schools as a research demonstration project.

The student assistance program now receives Federal funds through the block grant program; State funds through the New York State Division of Alcoholism and Alcohol Abuse, the New York State Division of Substance Abuse Services, and the New York State Health Department; as well as funds from each of the 19 participating high schools; and the DCMH.

Morehouse said that organizers of the student assistance program considered it "very important" that schools not have to pay for the program during the first year. "This relieved them of the pressure of having to say the program had been 'wonderful' simply because they were financially tied to it," she said. However, a school's participation in the program was contingent upon its principal (and the superintendent) agreeing to abide by several DCMH rules. First, because of drug and alcohol confidentiality laws, schools had to agree to allow students to participate in the program without obtaining parental consent and, in addition, had to waive the right to see any notes or records from the counseling sessions. Second, Morehouse said, each principal had to send a letter to the DCMH, acknowledging that his or her school had a definite need for the program and pledging full staff support for the project. "We started right at the top," Morehouse said, "to ensure that the administration and staff would really work with us." DCMH staff wrote in their first-year report on the program, "It is our impression that the support of the high school principals was one of the most important factors in making the program function effectively, since the principal successfully integrated the program into the individual school."

However, full staff involvement was integral to the program's success in the schools and to the concept of adapting the EAP model to an alcohol and drug intervention/prevention program, Morehouse noted. Like EAPs that train supervisory personnel to identify employees whose work performance has been negatively affected by alcohol, drugs, or personal or family problems and to direct them to the appropriate helping resources, the student assistance program counselors encourage teachers and other school staff members to look for signs that their students might need help. "First, we made each school district change to the '1, 2, 3' EAP philosophy," Morehouse said. Under this philosophy—which involves a wide variety of school personnel in activities ranging from identifying and referring problem students to taking disciplinary action against them—students who are caught with or under the influence of alcohol or other drugs are referred to the school nurse and then sent home. The next day, they are required to visit the student assistance program counselor. The second time they are identified, they are again sent to the counselor, and the third time, they are suspended. Morehouse said that after a student is suspended, the student and his or her parents must see the counselor.

Most parents have already heard about the student assistance program by the time they meet with the counselor. "When the program starts up in a school," Morehouse explained, "a letter goes out to all parents, introducing the counselor and explaining that this is a new way of dealing with 'high' students." The counselors employ a number of other methods to spread their message, including speaking at beginning-of-the-year faculty meetings, meeting with principals to learn what the "natural resistance" will be to the program in their schools, talking to student leaders to gain their pespective on the situation, and making presentations in classrooms.

Despite the fact that the program serves students with a diverse number of problems, alcohol was a dominant factor in the lives of most of the students counseled. Seventy-seven percent of the students seen during the first year were "target group" individuals, Morehouse said. That is, they were either children of alcoholics or abusing alcohol themselves. Counselors attempted to help these students identify their problems and reduce their feelings of isolation by assigning them to one of several "clear focus groups that included children of alcoholic parents, abusers, and students who didn't want to admit to or deal with their alcohol problems," Morehouse explained.

Another finding was that most of the students involved in the first year of the program were likely to bring similarly troubled friends to later sessions.

Finally, a positive response to the student assistance program has come from the school systems, also. Morehouse said that each of the schools is contributing $6,000 of its own money to continue the program after the first year. "And 13 other schools in Westchester county have similar programs with their own funding," she continued. This is possible, Morehouse said, because, "it is a very easy program to replicate." School personnel in New Jersey, Connecticut, Massachusetts, New Mexico, and a Seneca Indian community in upstate New York have already expressed an interest in the program.

For more information on the student assistance program, contact Ellen Morehouse, Westchester County Department of Community Mental Health, 234 County Office Bldg., 148 Martine Ave., White Plains, NY 10601.

—Jill Vejnoska

International Research Gains Renewed Interest

Special Focus on International Research Findings Prepared by Nancy Johnson, NCALI Staff Writer

Alcohol research is on the upswing in other countries, and the United States is taking renewed interest in research programs throughout the world, according to Boris Tabakoff, Ph.D., of the University of Illinois Medical Center in Chicago. Observations on developing research programs in Scandinavia, the Orient, Britain and Australia, and the Soviet Union were presented by Tabakoff, chairman of the newly formed International Society for Biomedical Research on Alcoholism, at a recent National Institute on Alcohol Abuse and Alcoholism (NIAAA) seminar.

Scandinavia

Much of the Scandinavian research has recently focused on TIQs (tetrahydroisoquinolines), chemical substances formed by combining the neurotransmitters (which carry brain cell messages) and acetaldehyde (the breakdown product of alcohol). It has been speculated that TIQs may cause addiction by acting on opiate receptors as morphine does. The Scandinavians force-fed alcohol to animals for a long time—250 days, he said—and they claim they have isolated the TIQs in the alcohol-consuming animals and not in nondrinking animals.

The Scandinavians also have developed a test to detect heavy drinkers, based on abnormalities that occur in transferin, a blood protein that binds and transports iron, he said. The person who consumes four to six drinks daily for a week can be detected with 80 to 90 percent accuracy. The transferin abnormality disappears when the person abstains for 2 weeks. This test could be useful in monitoring binge drinkers, Tabakoff said. Other blood test batteries being developed in the United States, based on routine blood tests, may prove more accurate and useful in the long run, however, he said.

In the Scandinavian countries, research received a significant boost recently when a research society was formed to study the biomedical aspects of alcoholism. In addition, Sweden has allocated $1.5 million this year for the development of three to four research centers, a sizable increase over the previous support, Tabakoff said. The Swedish Government also is supporting travel by its scientists throughout the world, and in both Finland and Norway, increased amounts of money are being channeled into alcoholism research, Tabakoff said.

The Orient

Alcohol research in Taiwan is getting underway, but Japan remains preeminent in alcohol research in that part of the world, Tabakoff said. Recent Japanese research has suggested that it is not so much the difference in the speed of acetaldehyde formation as a difference in ability to get rid of acetaldehyde that is the cause of the facial flushing experience by many Japanese when they drink. About 80 percent of the Japanese break down alcohol to acetaldehyde more rapidly than normal, and this had been hypothesized as the cause of the facial flush.

In another, more recent breakthrough, the Japanese have found that very few alcoholics in their country form high levels of acetaldehyde when drinking, Tabakoff said. This supports the hypothesis that acetaldehyde is a noxious substance that tends to inhibit drinking, and it casts doubt upon the current speculation that alcoholic drinking is associated with high TIQ levels that are the result of unusually high acetaldehyde levels.

The Soviet Union

The Soviet Union, in 1980, formed a Commission on Alcohol and Narcotics, Tabakoff said. Although drug abuse was not considered a major problem within the country, alcoholism was, as its prevalence was increasing. The problem caught the attention of political leaders who approved formation of the Commission, which now has two divisions—research and fiscal affairs. An advisory group of scientists is responsible for formation of research policy, Tabakoff said.

Dr. Irina Anokhina, who currently supervises alcohol research at the All-Union Research Institute of General and Forensic Psychiatry, has

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French Researchers Studying Effects of Drug

Propranol, a drug widely used in the U.S. to treat heart disease, also can prevent dangerous recurrent gastrointestinal bleeding in persons with cirrhosis of the liver, Dr. Didier Lebrec and colleagues of Hopital Beaujon in Clichy, France, report (*N Engl J Med* 305:1371-1374, 1981).

About one-third of deaths in cirrhotic patients are due to hemorrhage, and there is no accepted, long-range treatment for this condition, although doctors sometimes perform surgery to relieve pressure in the large veins leading to the liver. Propranol decreased pressure in these veins, the researchers found, and continued long-term administration of the drug helped to prevent recurrent gastrointestinal bleeding.

In the recent study, patients hospitalized with cirrhosis and gastrointestinal bleeding — but in otherwise good condition — were randomly assigned to one of two treatment groups. Thirty-eight patients received oral propranol in doses that reduced the heart rate by 25 percent, and 36 patients received a placebo that looked like propranol, but had no effect.

One year later, 96 percent of the patients in the propranol group were free of rebleeding, while in the placebo group, 50 percent had no rebleeding. Two patients in the propranol group died of infection and liver failure shortly after the study began; in the placebo group, four patients died of massive rebleeding.

The investigators concluded that "because of its efficacy and lack of serious side-effects, continuous administration of oral propranol at doses that reduce the heart rate by 25 percent can be recommended for prevention of rebleeding in patients with cirrhosis who are in otherwise good condition." They cautioned, however, that their experience was limited to patients in good condition who have taken the drug 1 year or less.

Propranol is the most widely used cardiovascular drug in the U.S., and has been approved for the treatment of arrhythmias, angina, hypertension, and migraine. Recently, the National Heart, Lung, and Blood Institute recommended approval of the drug for the treatment and prevention of heart attacks.

DID YOU SEND YOUR MAILING LIST UPDATE FORM ?

Japanese Researchers Study Enzymes, Body Chemistry

Traditionally, theories regarding the alcoholism rate in Japan have focused on diet, customs, and social norms. Japanese researchers found recently, however, that about half the Japanese population lacks one of the two enzymes that break down the acetaldehyde formed from alcohol in the body. This increased acetaldehyde results in intolerance to even small amounts of alcohol and may cause these individuals to curtail their drinking. In contrast, persons with both enzymes have a strong tolerance for alcohol and may drink to excess and risk becoming alcoholics, the researchers say.

Japanese researcher Shoji Harada, of Tsukuba University in Japan, began this research while studying in Germany in 1979. He examined the livers of 60 Japanese and 80 Caucasians and found that all the Caucasians had two aldehyde dehydratase enzymes, but half of the Japanese had only one. Aldehyde dehydratase is important because it neutralizes acetaldehyde into acetic acid, which is excreted by the body as carbon dioxide and water. Otherwise, if acetaldehyde reaches a certain level in the blood, the face flushes, the heart speeds up, and an individual becomes drunk.

Upon returning to Japan in 1980, Harada continued his research by analyzing cell enzymes in hair samples of university students. He found that students whose faces flushed bright red while drinking either lacked or had only a small amount of one of the enzymes that breaks down acetaldehyde. Recently, Takemitsu Henmi and associates of Tokyo University analyzed hair samples from 100 alcoholic persons and found that all but 1 had both enzymes.

Harada has concluded that the half of the Japanese population that flushes from only a little alcohol lacks one of the alcohol dehydratase enzymes and that this physiological reaction makes alcoholism rare among this half of the population. Persons with both enzymes, however, have a greater tolerance and are more likely to become alcoholic, Harada says.

According to Henmi, "While drunkenness is common, there are fewer alcoholics in Japan than in the West. The reason has nothing to do with different moral codes, as has often been claimed. Our findings show that the different body chemistry of Japanese gives them less tolerance for liquor."

(continued from page 4)

achieved widespread prominence among her colleagues for her work on the effects of alcohol on the brain, he reported. As a result, Russian clinicians are moving very quickly to translate some of her recent laboratory findings into useful therapies, Tabakoff said. For example, a major clinical application of her work has been the use of two drugs, apomorphine and naloxone, in detoxification.

Naloxone is given early in treatment, in daily doses, to reduce intoxication. Apomorphine is given to reduce the severity of withdrawal symptoms. It apparently stimulates dopamine systems, which are depressed with chronic alcohol use. In the U.S., naloxone has been tried only on a few patients in ethanol-induced comas, Tabakoff said.

The major difference between research in the United States and Soviet Union is the Soviet Union's strong reliance on clinical observation, he said. "It is difficult for them to get the materials and funds to do large scale and controlled clinical trials, so findings often are deduced on the basis of a large number of detailed patient observations," Tabakoff said.

Other Soviet investigators have found that naturally occurring alcohol levels in the body tend to be lower in alcoholic persons. They are now exploring how measurement of these levels might someday aid in prediction of risk for alcoholism, he said.

Britain and Australia

In England, a small group of researchers is also concentrating on TIQs, and in addition, they are testing naloxone. In the British medical journal *Lancet*, several followup studies have suggested that naloxone counteracts the depressant effects of alcohol, but a few suggested it does not.

Tabakoff reported that he has tested the drug's effect on ethanol-anesthetized animals in the U.S and has found similar results—some animals are sensitive and others aren't. He speculates that genetics may account for the differing responses, and advocates more routine use of the drug to treat patients in ethanol-induced comas in the U.S. "It won't cause further damage and could help the patient who had the right genes," he said.

Tabakoff reported briefly on research in Australia, a country that has recently formed a medical society to study alcohol problems. Clinical studies being done in that country use CAT scans to detect drinking-related changes in the brain that may relate to deficits in intellectual functioning. The proteins responsible for breaking down alcohol into simpler substances are also being studied.

For further information, contact Boris Tabakoff, Ph.D., Department of Physiology, University of Illinois Medical Center, P.O. Box 6998, Chicago, IL 60680.

U.S., Mexico Sign Pact To Combat Alcohol Problems

Mexico and the United States have entered into a bilateral agreement for scientific cooperation to combat alcohol problems in the two countries. The agreement was signed for the United States by Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Administrator William Mayer, M.D., and for Mexico by Ramon de la Fuenta, Director General of the Mexican Institute of Psychiatry.

The two countries will exchange information, scientists, and technicians, and will undertake collaborative pilot projects. At a meeting at the National Institutes of Health, Mexican and U.S. health officials explored specific areas for collaboration, such as biomedical, treatment, and prevention research; psychosocial and cross-cultural research; epidemiological surveys; and training and education.

The two countries also agreed to establish a joint steering committee to meet alternately in Mexico and the United States to review the status of cooperative activities, exchange information on policies regarding alcohol programs, and provide consultation to the two Governments on implementing the agreement.

alcohol digest

Alcohol Digest is a collection of items of interest to the alcohol field.

Family Coalition Seeks Information

The Family Resource Coalition, a grassroots federation of family support programs in the U.S., is seeking information for a national clearinghouse on family-related issues, including alcohol abuse. The coalition, located in Chicago, is devoted to building program networks at the State level, promoting the exchange of program information, and publicizing the value of community-based family support.

The coalition clearinghouse will include comprehensive materials on family support programs, technical assistance resources, and research related to family support. The coalition is made up of programs that range from cooperatives run by parents to programs associated with hospitals and social service agencies, from volunteer programs to programs with a large paid staff, and from neighborhood support groups to parent education classes.

For further information, contact Linda Lipton, Family Resource Coalition, 230 North Michigan Ave., Suite 1624, Chicago, IL 60601.

Hospital Develops Client Handbook

The Department of Alcohol Services at St. Vincent Hospital in Worcester (MA) has developed a client handbook that is distributed free as part of the intake process. The handbook discusses the disease concept of alcoholism, approaches to treatment, procedures for admission, and aftercare and community involvement, including Alcoholics Anonymous (AA), Al-Anon, and Alateen.

For further information, contact Department of Alcohol Services, St. Vincent Hospital, Worcester, MA 01604.

Manual Assists Groups In Developing EAPs

The National Council on Alcoholism (NCA) recently published *The EAP Manual*, a comprehensive guide for organizations interested in establishing employee assistance programs. The manual is designed to give business executives a step-by-step approach for dealing with alcoholism in the workplace and, according to NCA President John Doyle, "will tell employers how to set up such a system and how to make it work."

The manual is available for $6, and further information can be obtained from Bill Dunkin, National Council on Alcoholism, 733 Third Ave., New York, NY 10017.

Study Gathers Data On Treatment

The largest evaluation of alcoholism treatment activity in the U.S. was begun recently by Advanced Health Systems, Inc., of Irvine (CA), which owns and operates the Raleigh Hills hospitals across the Nation, and Texas Christian University.

The project, titled the Alcoholism Research and Management System, will be conducted at Raleigh Hills hospitals by TCU's Center for Organizational Research and Evaluation Studies. Researchers will develop a companywide system to monitor treatment processes and to evaluate treatment effectiveness. The project involves developing an automated recording system that will be used as a vehicle for data collection from patients in the hospitals. The project will also study what impact alcoholism treatment has on the utilization of other health care services.

For further information, contact Betty Donovan Knox, Director, TCU News Service, Texas Christian University, P.O. Box 30776, Fort Worth, TX 76129.

Newsletter Reports on Anthropology Research

The Alcohol and Drug Study Group of the American Anthropology Association has begun publishing a newsletter focusing on alcohol- and drug-related research currently being done in the field of anthropology. The newsletter reports on ongoing and planned research projects and also describes publications and meetings that relate to alcoholism research. The cost is $3 per year.

For further information, contact Genevieve Ames, Ph.D., Medical Anthropology Program, University of California at San Francisco, 1320 Third Ave., San Francisco, CA 94143.

Prevention Is Goal Of College Group

Students at Western New England College in Springfield (MA) have formed Peer Alcohol Resource Team and You (PARTY), a student group whose goal is to promote responsible drinking on and off campus.

The group has sponsored an alcohol awareness fair, nonalcoholic "bars" at campus events, and special activities during orientation week. Group members, who are required to attend six alcohol awareness training sessions sponsored by a local alcoholism agency, have also prepared a publication containing nonalcoholic drink recipes that is distributed free to incoming students.

For further information, contact Maureen Hart, Director of Student Activities, Western New England College, 1215 Wilbraham Rd., Springfield, MA 01119.

Presentations Foster Dialogues on EAPs

Breakthrough Concepts, a rehabilitation program of education and counseling located at Gracie Square Hospital in New York City, has begun a series of educational presentations directed to administrators and counselors in employee assistance programs (EAPs).

The series, titled "Topics and Issues," attempts to open a dialogue between professionals involved with care in the hospital setting and organizational professionals involved with the referral process in the work setting. Presentations focus on topics and issues that are relevant to both groups in understanding alcohol and drug abuse.

Topics have included "Counseling the Black Client," "Goal-Oriented Short- and Long-Term Counseling," and "The Mixed Substance Abuser."

For further information, contact Jim O'Donnell, Director, Occupational Health Program Relations, Gracie Square Hospital, 420 East 76th St., New York, NY 10021.

meetings

Nov. 7-14, 1982 and June 19-24, 1983. Minneapolis, MN. Working With Parents. Contact Community Intervention, Inc., 220 South Tenth St., Minneapolis, MN 55403.

Nov. 7-14, 1982 and May 15-20, 1983. Minneapolis, MN. Treating the Adolescent in Trouble With Alcohol and Drugs. Contact Community Intervention, Inc., 220 South Tenth St., Minneapolis, MN 55403.

Nov. 8-9. Coatesville, PA. Sixth Annual Coatesville Jefferson Conference on Addiction Research and Treatment: Alcohol, Drugs, and Aging — Development, Diagnosis, and Treatment. Contact Keith A. Druley, Ph.D., Coatesville VA Medical Center, Great Hall, Bldg. 5, Coatesville, PA 19320.

Nov. 8-11. Minneapolis, MN. Family Reconstruction Workshop. Contact Onsite Training and Consulting, Inc., 1645 Hennepin Ave., Suite 206, Minneapolis, MN 55403.

Nov. 11-13. New York, NY. Women and Work. Contact Women in Crisis, Inc., 37 Union Square West, New York, NY 10003.

Nov. 13-18. San Juan, PR. Ninth Annual International Conference on Alcohol, Drugs, and Traffic Safety. Contact Dr. Sidney Kaye, GPO Box 5067, San Juan, PR 00936.

Nov. 14-Nov. 18. Minneapolis, MN. Family Reconstruction Workshop. Contact Evie Silverman, ONSITE Training and Consulting, Inc., 1645 Hennepin Ave., Suite 206, Minneapolis, MN 55403.

Nov. 15-19. San Francisco, CA. An International Perspective on Substance Abuse: The Problem, Its Treatment, and Medical Education. Contact Dr. Charles Buchwald, Conference Coordinator, Downstate Medical Center, 450 Clarkson Ave., Box 129, Brooklyn, NY 11203.

Nov. 15-19. Oakland, CA. An International Perspective on Substance Abuse: The Problem, Its Treatment, and Medical Education. Contact Dr. Charles Buchwald, Conference Coordinator, Downstate Medical Center, 450 Clarkston Ave., Box 129, Brooklyn, NY 11203.

Nov. 21-24. San Diego, CA. National Conference on Alcoholism and the Family — Western Edition. Contact Neil Scott, executive director, Foundation for Alcoholism Communications, 352 Halladay, Seattle, WA 98109.

Nov. 30-Dec. 1. Center City, MN. Alcohol/Drug Dependency and Mental Illness. Contact Marilyn Brissett, Continuing Education, Box 11, Center City, MN 55012.

LISTLESS?

These days it doesn't pay to be. It's especially easy to get left behind in the fast-paced alcohol world, where time speeds by, money sometimes runs out, and innovative ideas constantly overtake each other. To help you keep up, the National Institute on Alcohol Abuse and Alcoholism's Clearinghouse offers reading lists and resource lists.

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Editor: John Small
Art Editor: Julie Kurz

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NIAAA
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IFS No. 102
December 1, 1982

From the National Clearinghouse for Alcohol Information of the National Institute on Alcohol Abuse and Alcoholism

DHHS Secretary Announces Teenage Alcohol Initiative

Department of Health and Human Services (DHHS) Secretary Richard S. Schweiker recently unveiled plans for a teenage alcohol initiative that he said will "give direction and momentum to the national sense of horror over the tragedy of alcohol abuse by young people." Secretary Schweiker detailed the "combined national effort by government and the private sector" at the first of a series of alcohol and drug prevention conferences sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) as part of the initiative.

Speaking in San Francisco, Secretary Schweiker emphasized not only the tragic nature of teen alcoholism and alcohol abuse, but also DHHS's determination that "the memory of too many past tragedies will save other lives tomorrow." Toward that end, he said, the Department developed the initiative, which establishes strong prevention activities as the key to reducing the Nation's youth alcohol problem.

Saying that "if alcohol abuse is a sickness, then today an epidemic is stalking our young people," Secretary Schweiker cited the following statistics having to do with youth and alcohol:

- Approximately 10,000 youths between 16 and 24 die in alcohol-related motor vehicle crashes each year — the leading cause of death in this age group. "Each year, a staggering ten thousand young lives, rich with promise, are snuffed out," he said.
- Approximately 3 million of our young people between 14 and 17 have problems with the use of alcohol.
- About one in every four 10th to 12th graders drinks at least once a week. Fifteen percent of such youngsters in the peak of their formative years drink heavily once a week. Six percent of 12th graders drink daily.
- More senior high school students today use alcohol than any other psychoactive drug. "Even more important," he said, "teenagers often combine alcohol use with other drugs . . . with potentially deadly consequences."

The initiative has four components, the Secretary said, the first being the series of NIAAA-sponsored conferences on teenage alcohol and drug prevention that were held in each of the 10 DHHS regions during October and November. These conferences, he said, were designed "to help teachers, school principals and administrators, PTA representatives, school board members, and others in local communities across the Nation start or expand alcohol and drug abuse prevention and education programs."

The second component of the initiative is a series of NIAAA-sponsored regional meetings to be held next summer to train program administrators in assessing the need for and designing comprehensive treatment services for youth. "We will be encouraging private industry to endorse and support these prevention and treatment programs in their communities," the Secretary said.

Third, he said, "I have directed the various components of my own Department to collaborate in research, education, prevention, and treatment activities that have a bearing on teenage alcohol abuse." As he explained, "Research can provide us with valuable data on the impact of education and prevention programs and on the effect of actions such as changing the legal drinking age." Also, the Secretary said, "DHHS has communicated the continuing support of the U.S. to the World Health Organization (WHO) for its efforts regarding teenage alcohol abuse. And President Reagan's request for alcohol research in the fiscal year 1983 budget increases funds for that purpose by 59 percent, from $20.8 to $32.9 million."

He said that the centerpiece to the teenage alcohol initiative will be a Secretarial conference in Washington in the spring of 1983 to draw national attention to the fine work of the growing youth movement called Students Against Driving Drunk (S.A.D.D.) and other similar ventures. "I am asking other Cabinet officers to join me in this effort."

S.A.D.D., which originated in a small Massachusetts community, has grown to a nationwide movement that promotes health education programs for students who will soon be acquiring drivers licenses. A feature of the S.A.D.D. program, which Secretary Schweiker said "particularly impressed" him and which he hopes will be replicated in many communities, calls upon teens and parents to sign contracts to the effect that they will not drive drunk and they will arrange alternative transportation for any signee who is too drunk to drive. A key clause in the contract states that no questions will be asked at the time such arrangements have to be made, but that a full discussion will take place "at a later time." Secretary Schweiker said he believes S.A.D.D. "deserves our strong endorsement and nationwide exposure," and explained that the purpose of the conference (to which student leaders from across the country will also be invited) will be to foster local initiatives along these same lines.

Secretary Schweiker said he is "truly gratified by the expressions of support we have already received for this new initiative." However, the Secretary indicated there is more that individuals — particularly parents — can do to aid the initiative. "They can make sure their children have adequate information about the effects of alcohol on their minds and bodies," he said. "They can make certain that their sons and daughters do not have easy access to alcohol in the home. They can have frank communication about early use of alcohol, and they can stand by their son or daughter, should a course of treatment be found necessary if they get into trouble with alcohol."

The initiative is noteworthy, Secretary Schweiker said, in that it draws on the strength and dedication of a diverse group of individuals, including teens, parents, members of the educational community, business leaders, and government officials.

For more information on the teenage alcohol initiative contact Edward L. Kelly, Coordinator, Secretarial Initiative on Teenage Alcohol Abuse, NIAAA, Room 16-105, 5600 Fishers Ln., Rockville, MD 20857.

— Jill Vejnoska

HE 20.8312:

Blood Tests May Help Diagnose Liver Disease

Routinely requested blood tests associated with regular physical exams or hospital admissions appear a promising new way to diagnose liver disease, say Ralph S. Ryback, M.D., and Michael J. Eckardt, Ph.D., of the National Institute on Alcohol Abuse and Alcoholism's Division of Intramural Research, and Robert R. Rawlings, M.S., of the Statistical and Mathematical Applications Branch of the Alcohol, Drug Abuse, and Mental Health Administration.

A previous issue of the *NIAAA Information and Feature Service* (No. 89, Oct. 28, 1981) reported on the potential value of using quadratic discriminant analysis of 25 routine blood tests in diagnosing alcoholism. The same researchers now report that the technique is useful in confirming a diagnosis of liver disease and in distinguishing persons with liver disease caused by alcohol from those with other types of liver disease.

A tentative diagnosis of liver disease normally can be made on the basis of laboratory measurements of enzymes in the blood, a patient history, and a physical examination. If necessary, a biopsy can be done to confirm the diagnosis as well as to determine the cause of the liver disease, Ryback said.

Prognosis and treatment often differ depending on whether alcohol is involved. For example, when hepatitis, an inflammation of liver cells, is caused by alcohol, the best way to stop progressive deterioration of the liver is to stop the person's drinking. Other forms of hepatitis that are viral in nature, however, may respond to corticosteroid drugs that reduce inflammation.

Using a biopsy to confirm a diagnosis is an invasive and sometimes painful surgical procedure that involves use of local anesthesia and insertion of a needle through the abdominal wall and into the liver to withdraw a specimen, a procedure not entirely without some risk to the patient. Some patients may not want to have it done; some medical conditions preclude it; and in some cases, the liver disease is so minimal the physician is reluctant to order it.

If the new technique proves successful, it could be a useful adjunct for the physician who wants to confirm a difficult diagnosis, and might even preclude use of a biopsy in some cases. "These chemical tests have been used for a long time. We just hope to get more information out of them," Ryback said.

In order to make the diagnosis, 25 test values are analyzed as part of 3 separate test batteries: the SMA 6, SMA 12, and the hematological series. Physicians commonly order these three groups of tests to screen for potential problems or to identify nonspecific patient complaints.

Abnormal values in some of the individual tests have been noticed among alcoholics for many years, but the investigators were the first to use an available statistical technique, quadratic discriminant analysis, to examine all 25 values for distinctive changes in their relationship to each other. The technique is similar to use of a fingerprint. A single line examined individually will never identify an individual, but examination of all 25 lines in relationship to each other is more accurate, Ryback said.

The investigators tried to correctly classify four groups of patients from the Veterans Administration Hospital Medical Center in Long Beach (CA); assisting was Bertram Felsher, M.D., then of that facility. One group consisted of 51 patients with biopsy-verified alcoholic liver disease who drank an average of 10 to 12 drinks daily. Another group included 56 patients with biopsy-verified nonalcoholic liver disease; this group had no medical or self-reported history suggestive of alcohol-related problems and averaged one to three drinks monthly. A third group consisted of 60 participants in an alcoholism treatment program with a primary medical diagnosis of alcoholism who averaged 13 to 15 drinks daily. Although a biopsy was not considered warranted, there was presumed mild liver involvement because 50 percent had elevated liver enzyme levels and 5 percent had a palpable liver. A fourth group contained 57diagnosed nonalcoholics without liver disease who had a variety of other medical conditions and who had averaged one to three drinks per month during the previous six months.

Statistical analysis of the 25 tests correctly classified 100 percent of the nonalcoholics without liver disease, 98 percent of the treatment program patients, 96 percent of alcoholics with liver disease, and 89 percent of the nonalcoholics with liver disease. Most important, the test also distinguished all patients with alcoholic liver disease from those with nonalcoholic liver disease.

The diagnostic utility of the procedure was also tested on undiagnosed patients to gain a closer approximation of the procedure's usefulness in a clinical setting. Among 12 persons later shown to have alcoholic liver disease, 10 were correctly diagnosed with the technique, an 83 percent accuracy rate. Also five of six were correctly judged to have nonalcoholic liver disease, also an 83 percent accuracy rate.

Although few patients were tested, the procedure was clearly superior to the use of measures of liver enzymes, particularly in the diagnosis of nonalcoholic liver disease, the researchers said. Liver enzyme values could identify correctly only 33 percent of the patients with nonalcoholic liver disease and 75 percent of those with alcoholic liver disease.

In addition to its significant potential for diagnosing alcoholism, the test appears to have some promise in the area of identifying individuals with nonalcoholic liver disease. The basis for this is that the researchers were able to separate out individuals with nonalcoholic liver disease solely on their analysis of the biochemical tests from individuals who had no liver disease. Further research will explore whether this technique is applicable in the differential diagnosis of jaundice as well as in the early identification of pregnant women with alcohol problems, thus providing a means of primary prevention for the fetal alcohol syndrome.

Much further testing remains before widespread use of the technique is feasible, however. The study is currently being repeated among a larger population at the National Naval Medical Center in Bethesda (MD). The investigators are also studying women to see if results are similar. The next step is to use the tests in a clinical setting such as a large hospital to see how they work in everyday practice.

The research appears in the November 12, 1982 issue of the *Journal of the American Medical Association*.

For further information, contact Ralph S. Ryback, M.D., NIAAA Division of Intramural Research, NIH Building No. 10, ACRF, Room 3C 217, 9000 Rockville Pike, Bethesda, MD 20205.

— Nancy Johnson

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meetings

Dec. 6-10. New York, NY. Clinical Decision Making in Alcoholism and Drug Abuse. Contact Andrew Gordon, Ph.D., Smithers Alcoholism Treatment and Training Center St. Luke's-Roosevelt Hospital Center, 428 West 59th St., New York, NY 10019.

1983

Jan. 27-Feb. 1. Clearwater Beach, FL. Fourth Training Institute on Addictions. Contact Dan Bartmettler, Director, Institute for Integral Development, P.O. Box 2172, Colorado Springs, CO 80901.

Feb. 14-18. Denver, CO. Managing a Successful Employee Assistance Program. Contact Paul Hoover, Director, Bethesda Employee Assistance Services, 4400 East Iliff Ave., Denver, CO 80222.

Correction

The correct spelling of the drug described in a story in IFS #101 on gastrointestinal bleeding in persons with cirrhosis of the liver is propranolol.

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EAP Training Courses To Be Presented

The National Occupational Program Training Institute (NOPTI) has developed a 5-day training course *Occupational Program Administration: Managing a Successful Employee Assistance Program* to be presented in various cities in upcoming months. The course is designed to improve the knowledge, skills, and effectiveness of managers of EAPs in public and private work settings and focuses on a range of issues important to planning and day-to-day operations. These issues include problems in the workplace, the role and function of EAPs, health insurance, labor unions, data collection, environments of EAPs, and program promotion and planning. Sessions include role playing and small-group work. The training events will be co-sponsored by local organizations.

For further information, contact Yvette Washington, NOPTI Registrar, 5530 Wisconsin Ave., Suite 1600, Chevy Chase, MD 20815.

Coming in IFS #103:

A Special Report on Alcohol and the Elderly

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Recently, subscribers to *Alcohol Health and Research World* enjoyed issues focusing on such topics as drinking and driving, alcohol and youth, and alcohol and family violence. Upcoming issues will feature: a look at statistics on drinking and driving among youth, with a discussion of implications for program planners and policymakers; coverage of alcohol and blood sugar disorders; a special issue on broadbased efforts to integrate alcohol and drug abuse information into the educational programs of medical, nursing, and other health professions schools; and ongoing coverage of alcoholism and related topics.

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Alcohol Problems in Elderly Compounded by Many Factors

Alcohol and the Elderly

A Special Report

Joe S. is 70 years old and has had problems with alcohol all of his life. He is retired, both he and his wife live on his pension, and he does not stay in touch with his son, who lives 2,000 miles away. He has problems with his liver and heart, and because he has difficulty "making ends meet," he stays nervous and upset.

Bill E. is 75 years old and has been a widower for more than 10 years. Most of his friends are gone and, like Joe S., he lives on a limited income. He has a bad back and heart, his eyes are not what they used to be, and he just cannot seem to remember the things he used to. He has to take medication each day, but combines it with his usual "sip" of alcohol. Bill had never had a problem with alcohol in the past, but nowadays he gets a little "tipsy" sooner than he used to; however, these are the only times that he really feels good.

What's happening with these two individuals is not unusual. Today, senior citizens (aged 65 and older) comprise more than 10 percent of the total population; that's more than 22 million people, double the percentage in 1920. Seniors are the second fastest growing population group in the U.S. and, by the early 2000s, approximately 16 percent of the U.S. population will be 65 or older.

Many of these individuals experience loneliness, anxiety, alienation, isolation from the mainstream, and lowered self-image. As a result, researchers say, some are turning to alcohol. Researchers generally acknowledge two groups of problem-drinking senior citizens: early onset (like Joe S.) and late onset (like Bill E.). Early onset abusers are those who have beaten the statistical odds by surviving into old age despite prolonged heavy drinking. These individuals may have severe medical problems such as liver cirrhosis and brain damage and psychological problems. Late onset drinkers have developed drinking problems in later years, often as a result of or in reaction to a dramatic change in lifestyle — such as loss of mate, mandatory retirement, or other situations that may have forced them out of the mainstream of activities. These individuals rarely show the physiological signs of prolonged problem drinking.

While the drinking rate among senior citizens is lower than that of the general population, the rate of alcoholism problems is about the same — approximately 10 percent of the elderly population is experiencing some form of alcohol-related problem. And among those with additional medical, family, or emotional problems, the rate can be as high as 25 percent.

In general, many common signs attributed to aging can actually be indicative of problem drinking. For example, brain damage, heart disease, and gastrointestinal disorders that frequently result from problem drinking are also characteristics of old age. Further, much of what goes into diagnosing alcoholism — depression, memory loss, mood changes, and dramatic changes in employment, economic, or marital status — can be behavioral or psychological concomitants of old age. Therefore, problem drinking among the elderly is not always diagnosed as such.

Another problem for the elderly is their decreased tolerance for alcohol, which results from the natural slowing down of the metabolic process. Consequently, even those senior citizens who drink less than younger individuals, and in many cases less than they are used to, often experience increased effects of alcohol.

In the treatment area, however, a great deal of success is being reported. For example, some care providers have found that by addressing the special needs of the elderly — for companionship, medical care, etc. — elderly clients can improve their chances of recovery from alcohol problems. Also, not as many of the elderly seem to need the kind of detoxification normally required by younger alcoholics, although their detoxification may take longer. In addition, treatment for the elderly often includes a wide range of activities directed at relieving the social and psychological stresses associated with aging. Emphasizing useful activities, such as voluntarism and recreational programs, often gives elderly problem drinkers a new activity around which to structure their lives. Other programs combine close medical supervision, vocational rehabilitation, and efforts toward moving clients back into the mainstream. Educating the staff about the special needs of elderly alcohol abusers is also important because it improves the treatment environment.

Most researchers and treatment providers also note the importance of effective followup and aftercare, and — when indicated — home visitation by staff and neighbors. Community senior citizen centers seem particularly well suited for this role and have met with a fair amount of past success for two reasons. First, the centers offer multiple services and activities that do not pressure the individual client to seek only alcohol services. Second, the services are centralized, which is appealing to the individual with limited financial and transportation resources.

Community centers and other facilities for the elderly can also be effective environments for prevention and education activities because large groups of older Americans meet and spend a significant part of the day there. Church groups can also provide an atmosphere conducive to promoting awareness of alcohol and other drug abuse. Available data also suggest that prevention programs can be particularly effective with late onset problem drinkers among the elderly. Programs that are designed to increase the awareness of professionals who work with elderly alcohol abusers are also important, as are activities that help the elderly overcome feelings of loneliness, anxiety, and powerlessness.

— Millree Williams

HE 20.8312:

Alcohol and the Elderly

Treatment Approaches

Long Beach Program Blends Treatment, Support Groups

Long Beach (CA) is addressing alcohol problems among its elderly population thanks to a communitywide network of service facilities. The city's 72,000 older people now have access to a 3-week inpatient program at Memorial Hospital Medical Center — the Alcoholism Treatment and Education Center (ATEC) — and later to Helping Hands, a continuing communitywide support group that, in the words of support group founder Janet Ashton Glassock, "is designed to prevent the cyclical return of older alcoholics to the hospital."

Special attention to the needs of the elderly is essential at ATEC, where, it is estimated, between 15 and 25 percent of the inpatient population is over 60. ATEC's multifaceted approach is designed to "increase the treatability and prognosis of elderly alcohol abusers and reduce the need for hospitalization," says Glassock.

ATEC's inpatient program, though geared toward treating the alcohol problems of all age groups, also contains components that have been specifically designed to meet the needs of older patients. For example, Glassock says, "Because their detoxification and clearance may take up to twice as long as for younger drinkers," this is addressed over the course of Phases I and II of the program. In addition, multiple drug abuse is often a significant problem among older patients and the program's early phases have been amended to address these issues. As Glassock explains, "Initial contact includes inquiry about immediate environmental and personal issues that may need to be addressed to free the patients of anxieties, such as pets left at home alone, unlocked doors, or forgotten glasses, dentures, hearing aids, or clothing." Also discussed are drug use by patients, relationships of significant others, and the suitability of their environment in regard to continued recovery after discharge from the program. Every effort is made to involve the family, close friends, or neighbors in the recovery process, Glassock says. This might include conferences to discuss treatment and discharge plans and family meetings throughout the week.

In fact, exposing clients to persons who can help them through recovery is the single most important element of ATEC's special approach to treating older alcoholics. In the early stages of the recovery process, this often involves other recovering seniors. During Phase I — which includes family and individual counseling, didactic lectures and films, and orientation to Alcoholics Anonymous (AA), Women for Sobriety (WFS), and other groups — volunteers and older patients who have progressed to Phase II of the program are encouraged to visit those who are still in Phase I, Glassock says. And older inpatients are situated near one another "to encourage a sense of camaraderie and cohesiveness." Counselors also support recovery by helping the client develop enthusiasm for living and providing an environment in which to begin life anew. During Phase I, Glassock says, "the evaluating counselor looks for strengths, interests, and other significant factors that can be restored and redirected to contribute to the recovery process. These elements are taken into consideration as the treatment plan is developed by the patient and the multidisciplinary treatment team."

Sober living — more specifically, sober living amid the many changes brought on by the aging process — is the focus of Phase II of the ATEC program. A special daily therapy group addresses these life changes and teaches patients to trust and communicate with others. Attitudes toward alcoholism and alcohol abuse are discussed in the sessions because, Glassock says, "the older alcoholic sometimes resists help and denies his or her problem because of moral attitudes about alcoholism." It is the purpose of Phase II to provide elderly alcoholics with "motivations and commitments to sobriety," Glassock says. For some, that motivation may be the desire to ward off further problems at a time when they are increasingly hampered by physical disorders. For others, the restoration of family relationships or improved self-esteem may be the motivating factor.

ATEC patients are also encouraged to attend Helping Hands, a free support group, open to all elderly individuals who have a problem with alcohol. The twice-weekly meetings, begun in 1976, are attended by ATEC inpatients, former patients, and older persons of long- or short-term sobriety from the various communities in which the meetings are held. Glassock explains that "discussion centers on living in the here and now and making the most of each day. The group members are primarily oriented toward replanning their lives, setting new goals, and learning new skills and ways of achieving their goals." Helping Hands combines elements of AA, WFS, and cognitive approaches, involving individuals in peer discussions about retirement, economic and personal matters, community resources, and other problems associated with growing old. But "the most important function" of Helping Hands, Glassock maintains, "is the sharing of common aging and alcoholism-related problems, ways to stay sober, and the rewards of sobriety."

Glassock credits Helping Hands with helping to break through the barriers to communication that many elderly alcoholics erect. The warm, receptive atmosphere helps them not only to talk about their own problems and thereby maintain sobriety, but also, "once they begin to feel comfortable, to open up, gain confidence, and eventually reach out into the community and help others." After a while, the recovering elderly alcoholic is able to maintain sobriety and to extend the "helping hand" to others. Glassock says that members volunteer to make phone calls to newly sober seniors, and to conduct peer counseling and followup activities. Others have started Helping Hands groups in their home communities after they leave Long Beach. "While these groups address the same issues, they are autonomous and have been developed to meet their own local needs," Glassock says. Special Helping Hands group meetings have covered such topics as nutrition, arthritis, and senior community service activities.

ATEC and Helping Hands have also established community ties with a number of Long Beach social service agencies. For example, a workshop on curtailing alcohol abuse among seniors was

(continued on page 3)

San Francisco Program Provides In-Home Services

The staff of the North of Market Senior Alcohol Program in San Francisco (CA) log many miles as they travel door-to-door to provide in-home therapy for elderly persons with drinking problems.

In-home services were begun in 1973, shortly after the North of Market Health Council opened a clinic to serve the medical needs of senior citizens. Staffers who visited the elderly found that a large number were having problems with alcohol, in addition to other health problems, and began the alcohol program.

According to clinical supervisor Karen Fishkin, M.S.W., the elderly person may begin drinking to cope with the stresses of old age, i.e., deteriorating health, retirement, and the death of spouse or friends. These stresses are often exacerbated by feelings of isolation and withdrawal from the community, she said. The elderly also are particularly susceptible to drinking problems because their tolerance to alcohol is less than that of younger people and they may face increased risks because of the prescription drugs they take.

Program therapy at North of Market is individualized and holistic, using a care model approach that takes into consideration all aspects of the person's life. Both group and individual counseling are available.

Referrals for home visits often come from the medical clinic affiliated with the program. A discharge planner, for example, may have visited a patient previously hospitalized with a broken hip and discovered a drinking problem. A frequent visitor to the clinic may exhibit unusual behavior and be referred. Inservice programs conducted for agencies may bring in referrals. Many clients are referred by the management of local hotels catering to seniors. Others come from the street.

The five-person traveling staff includes a social worker, a nurse, a recovering alcoholic, a psychology student, and a Mennonite volunteer. Each client is seen once a week for 1 to 2 hours and more often in times of crisis. Altogether the staff makes about 450 hours of home visits per month. Visiting may continue indefinitely.

About 70 percent of the referred persons refuse services, but with the 30 percent who accept, there are often good results. Over the 6 years of the program's existence, better than 50 percent have remained sober or have had their periods of sobriety enhanced, according to program administrators.

Some people are referred two to three times. "We always go to see them again, since they may have had a life crisis or changed their minds," she said.

Although staff see almost everyone who is referred, they regret not having the time to spend with those who need help but aren't ready to accept it. "We're missing a lot of people. Many we get to haven't made the decision to stop drinking," she said.

Providing clients with meaningful activities is also important in reducing recidivism. For some, crafts and hobbies will work, but for many, voluntarism is the answer.

The North of Market program also sponsors a storefront recreational drop-in facility that provides an alcohol-free social environment where 50 to 75 treatment program alumni visit daily. "Loneliness and isolation and staring at four walls is a big factor in returning to drinking. Unless we can provide an alternative, it's not too long before they're back drinking," she said.

The drop-ins play cards, talk, and take part in organized activities such as trips to museums and ball games. Three Alcoholics Anonymous (AA) meetings are held weekly. Referrals are made for those in need of temporary housing or food.

The North of Market Senior Alcohol program is funded with Federal block grant and State monies through the Community Substance Abuse Services, a city government agency. Clients pay between $1 and $5 a month for services, and must sign a contract to stay involved with the program. Said Fishkin, "We get mainly a commitment of time, not money."

For further information, contact Karen Fishkin, Clinical Supervisor, North of Market Senior Alcohol Program, 333 Turk St., San Francisco, CA 94102.

— Nancy Johnson

(continued from page 2)

conducted at the Long Beach Senior Center by the Long Beach Alcoholism Coalition, the Senior Care Action Network, and other senior agencies. These agencies refer patients to ATEC, as do alcoholism treatment programs, hospitals, and senior agencies throughout the greater Long Beach and Los Angeles areas and Orange County. Representatives from various community agencies devote much time to speaking at Helping Hands, and to involving recovering seniors in such activities as Meals on Wheels and the Retired Senior Volunteer Program (RSVP).

In addition, Glassock says, gerontology and alcohol studies students from several California universities have done field placement training at MHMC-ATEC, working with Helping Hands groups and older inpatients. "This has not only provided a practical application of their academic work but stimulated numerous undergraduate papers, classes on alcoholism and aging, and graduate level research projects," Glassock explains.

Ultimately, Glassock believes, increased educational and lay interest in the subject of alcoholism will aid senior citizens. "With increasing education and the acceptance of alcoholism as a treatable disease and as America's number one drug abuse problem, group meetings and counseling may become an accepted part of senior service facilities."

Although the program administrators do not have any hard data on recovery rates, they have found that many older people who come through the program "develop motivation for sobriety and reasons for living, thereby changing their habitual drinking. It appears that those who do slip, drink less, and often readmit themselves to the hospital and the Helping Hands program."

The program receives referrals from area hospitals and alcoholism treatment programs and from senior service agencies. The program is privately operated and receives no direct Federal or State funds. The Helping Hands support groups are run by Janice MacDonald Tully, alcohol rehabilitation counselor and current Helping Hands coordinator.

For further information, contact Janet Ashton Glassock, or Janice MacDonald Tully, Helping Hands Coordinator, Alcoholism Treatment and Education Center, Memorial Hospital Medical Center, 2801 Atlantic, Long Beach, CA 90801.

— Jill Vejnoska

Care of Elderly Alcoholics Focus of Minneapolis Center

What makes the Queen Nursing Home and Treatment Center in Minneapolis (MN) unique is the uniformity of its clientele. It is one of the few facilities in the country devoted exclusively to caring for elderly alcoholics.

"Caring" is the operative word at Queen, where staff are attentive to both the physical and the emotional needs of patients. Former administrator LaVerne Gordon explains, "Their illness is alienation as much as it is alcoholism, and this combination requires a special effort of openness and giving from the staff if the lives of the older problem drinkers are to be made any easier."

An ordinary nursing home until 1973, Queen began offering alcoholism care services in addition to nursing care. The average age of the clients is 60.

Assistant administrator Bev Kinney believes that the elderly people seen at Queen do not suffer a form of alcoholism markedly different from younger people. "Elderly people have additional physical problems, so naturally there are some medical diagnoses involved with that group," Kinney says, "but beyond that, we don't see too many differences."

Why, then, a separate facility for elderly persons with drinking problems? While the disease is the same for young and old, the attitudes of older alcoholics require a special orientation on the part of the staff. Kinney explains that "only about 1 percent of our patients are able to comprehend that their alcoholism is a disease needing treatment." The majority of the people seen at Queen suffer from alcoholism as well as other medical and social problems, and consequently need staff support with daily living as well as with their problems with alcohol.

"We do this by imposing certain restrictions on patients," says Kinney, including closely monitoring visits by relatives and others to ensure that they have not been drinking or will not attempt to smuggle liquor to patients, and requiring that patients "earn the right to handle their own money." Kinney explains that upon entering Queen, all patients surrender their money to the admitting nurse or social service director, who eventually parcels it out to its owners in the form of an allowance. This policy, Kinney says, is designed to help maintain client sobriety. According to Kinney, "We had one man who hid his food stamps when he was brought in. Later, we found that he was using those stamps to buy alcohol."

A constant, focused effort such as this requires a dedicated staff knowledgeable about alcoholism and other problems of the elderly patients. According to Kinney, "Many of our staff have personal knowledge of alcoholism, usually through their families. Therefore, they are able to look beyond the personality — the anger — of an elderly alcoholic and see that that person is sick with a disease." In addition, Kinney says that inservice sessions, as well as information sharing by house physicians who "have a special interest in alcohol abuse and who are always updating their knowledge," keep Queen staff informed about elderly alcoholism.

Another factor, one that allows staff to empathize with the plight of their patients, is the personal battle that many of them have fought with alcoholism. "Many of our staff are recovering chemical abusers," Kinney explains. Many are also members or strong proponents of Alcoholics Anonymous (AA) and encourage patient attendance at Queen's own AA group.

Care at Queen is geared toward broadening the periods of meaningful activity in patients' lives. Often, Kinney says, elderly persons drink because they are lonely or bored, and have little else to do. In the course of the day, every able-bodied patient is responsible for a maintenance chore plus some form of handiwork such as leathercrafting, sewing, or painting. Instead of making something with his hands, one patient chose to maintain the nursing home library.

Kinney believes that society's views must change if the rate of elderly alcoholism is to be reduced. "Drinking problems among the elderly are much more common and more severe than society thinks," she says. "Many older people are lonely, with their families far away, and so they use drinking as a crutch." This problem, Kinney says, is "hard to see because many of us don't want to see it."

Another problem is the preponderance of high-rise apartment complexes in Minneapolis and other areas that, according to Kinney, sometimes "hide" elderly alcoholics from public view. While she maintains that it is good that older people can live in their own apartments, she also feels that it is "very easy for them to withdraw" behind locked doors.

Queen staff and clients occasionally travel to area high rises for activities such as bingo, and sometimes invite high-rise residents to visit Queen. In addition, Kinney says that she chats with legislators who periodically visit Queen, alerting them to the seriousness of alcoholism, overprescription of medicines, and other problems affecting the elderly. "First of all, everyone has to admit that these are problems," she explains. "It hasn't exploded yet, but if we ignore it, it could."

Many of their referrals come from the general hospital, medical centers, and other long-term care facilities and hospitals in the Minneapolis area. Other referrals come from area detox centers.

Queen is a private corporation supported by patients' fees. Most of the patients, however, receive Medicare or Medicaid or private insurance reimbursement. A few pay out of private funds.

For more information, contact Bev Kinney, Assistant Administrator, Queen Nursing Home and Treatment Center, 300 Queen Ave., Minneapolis, MN 55405.

— Jill Vejnoska

Information Reviewed On Alcohol and Elderly

NIAAA's National Clearinghouse for Alcohol Information has prepared an In Brief entitled *Alcohol and the Elderly*. In Briefs are short (3 to 5 page) summaries that offer background information and highlight current knowledge on specific topics. *Alcohol and the Elderly* includes information on characteristics of elderly problem drinking, treatment methods, outreach needs, and prevention and education. It includes 51 references for further information.

This In Brief (order no. RPO 254) is available at no charge from the National Clearinghouse for Alcohol Information, P.O. Box 2345, Rockville, MD 20852.

Alcohol and the Elderly

Current Research

Researchers Probe Effects Of Alcohol on Elderly

Recent research findings have led some investigators to speculate that a form of premature aging may occur among alcoholics. Specifically, both groups — the elderly and alcoholics — show a loss of intellectual abilities as measured on tests of mental functioning. Rapid information processing, abstract reasoning, and formation of new memories appear most affected, with the performance of alcoholics closely mimicking that of nonalcoholics 10 to 20 years older. Abilities that draw upon experience and previously acquired knowledge, however, remain relatively stable.

In a recent symposium on Neurobiological Interactions Between Alcohol and Aging (*Alcoholism: Clinical and Experimental Research*, vol. 6, no. 1, 1982), a series of investigators reviewed relevant studies. The following are summaries drawn from many of the papers.

Social Drinkers

Elizabeth Parker, Ph.D., and her associates, of the Laboratory of Clinical Studies at the National Institute on Alcohol Abuse and Alcoholism (NIAAA), reported on two studies in which they found that even social drinkers experience some loss of abstraction abilities on cognitive tests. A similar loss was noted among older nonalcoholic persons.

Abstraction is the higher cognitive ability that allows one to see what is common or universal in things; the ability to complete a sequence, for example, is dependent on abstraction abilities.

Among two groups of employed men, test performance steadily declined as amount of alcohol typically consumed per drinking occasion increased; a similar decline was noted with increasing age. Frequency of drinking was not related to degree of impairment. An increase of one drink in the amount of alcohol typically consumed each drinking occasion was associated with an average reduction in abstraction performance equivalent to 3.7 years of age in one group and 2.4 years of age in the other.

The findings supported the investigators' speculation that "the combination of age and drinking might place the older drinker at double jeopardy for cognitive loss."

The researchers suggested that older people should be made aware of how alcohol use may affect already diminishing cognitive abilities.

Neuropsychological Perspective

Looking at alcohol and premature aging from a neuropsychological perspective, Christopher Ryan, Ph.D., of the University of Pittsburgh, observed that there are several different possible interactions between alcohol and aging, "at present, all equally plausible." Alcohol may accelerate the rate at which a person ages by detrimentally affecting the biological mechanisms that regulate the aging process, or it may cause structural and functional changes in the brain identical to those that occur during normal aging. Alternatively, alcohol may produce nonspecific changes in the brain that add to but are quite independent of changes produced during the course of normal aging, Ryan said.

Although the findings on tests of learning and memory are consistent with the premature or accelerated aging hypothesis, Ryan noted that one cannot conclude that alcohol speeds the aging process simply because alcoholics earn scores identical to those of older nonalcoholics. Different individuals may obtain the same scores on a particular test for very different reasons, he said. Qualitative analysis of individual responses is needed to determine if similar types of errors are made.

Furthermore, there is much other research that argues against any premature or accelerated aging process, Ryan said.

Evoked Potential Measurement

Evoked potential (EP) measurement involves the recording of the brain's electrical activity following delivery of a sensory stimulus. Data are provided on the level of sensory, perceptual, and cognitive processing in the brain.

"Despite gross similarities between EPs in alcoholics and in the elderly, closer scrutiny reveals significant differences between the two groups," said Bernice Porjesz and Henri Begleiter, of the Downstate Medical Center, Brooklyn (NY).

Although the electrical activity of alcoholics in some respects resembles that of healthy older people, in other respects it most resembles that of persons with brain damage or dementia, they said. "In conclusion, at the present time, the electrophysiological data suggest possible different underlying pathophysiology for alcoholism and aging, casting doubt on the credibility of the accelerated aging hypothesis in alcoholism."

Atrophy

Structural abnormalities that suggest atrophy appear within the brains of both alcoholics and the elderly, according to D. Adrian Wilkinson, Ph.D., of the Addiction Research Foundation in Toronto. Thus far, however, no studies have shown conclusively that alcohol is the cause of the atrophy seen in alcoholics. Furthermore, there appears to be only a weak correlation between atrophy and the functional impairment noted on cognitive tests, he said. Atrophy also commonly occurs in other diseases such as schizophrenia or anorexia, he said.

The Molecular Level

In a review of studies of alcohol and aging at the molecular level, Gerhard Freund, M.D., of the University of Florida, noted that few researchers have looked at possible interaction between the two processes.

However, he said, some studies of animals have shown that loss of brain cell receptors occurs with normal aging. One particular study reported that consumption of large amounts of alcohol over a quarter of the animal's life span resulted in a decrease in the density and affinity of one type of brain cell receptor. It was thought this might be related to an observed loss of learning and memory in the animals, he said.

Freund concluded that the investigation of interactions of the effects of aging and chronic alcohol consumption on central nervous system (CNS) receptors is only beginning. "However, this type of research could lay the foundation for an understanding of the molecular basis of the behavioral changes induced by alcohol abuse and aging," Freund said.

— *Nancy Johnson*

Research Center Funded For Studies on Elderly

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has funded a National Alcohol Research Center (NARC) on alcohol and aging at the University of Florida. The center, mandated by Congress, becomes one of the eight alcohol research centers (see related story below) currently funded by NIAAA's Division of Extramural Research.

According to center direction K. F. Finger, Ph.D., who is also associate vice president for health affairs at the university, the school will take a multidisciplinary approach to the research projects and draw on 20 faculty members from the departments of sociology, the neurosciences, pharmacology, clinical psychology, and medicine.

Eight projects have been funded, Finger said. The first is a sociological study that takes advantage of pools of data on the elderly collected by researchers in preceding years. They hope to determine the incidence and prevalence of alcoholism in persons age 60 and older, he said.

A second sociological study will follow elderly persons over time to assess the social and psychological factors that may be involved in the development of alcoholism. The reasons alcoholism develops and persists in the elderly are very likely different from those that lead to alcoholism in younger persons, Finger said, especially because their lifestyle is different and their outlook is often focused on past achievements rather than on goals for the future.

In another study, different types of drinking problems will be assessed and pattern-specific treatments for these problems developed and evaluated. For example, some elderly seem to begin drinking because they have too much free time, Finger said. This study will analyze how people allocate their time and will explore alternatives and appropriate methods of intervention.

In another study, investigators will examine how both human and rat cells age and whether the aging process is influenced by alcohol. "We're trying to establish whether alcohol has an effect on increasing the rate of aging," Finger said.

Investigators will also attempt to develop an animal model of alcoholism in aged rats, something that has never been done before. The rats' response to different dosages of alcohol will be assessed to determine the drug's effects on tissues, the liver, and the heart.

In a subsequent study, the effect of chronic ethanol administration on the heart will be assessed using the animal model developed. Researchers will study the relationship of alcohol consumption to hypertrophy (the overgrowth of a body organ), congestive heart failure, and electrophysiological changes in impulse conduction in the elderly. The interactive effects of alcohol and other drugs also will be looked at.

In another study, interactive effects of alcohol and aging in the hippocampus of the rat's brain, an area known to affect behavior, will be assessed. Finally, the pathological effect of alcohol abuse on human brain receptors will be studied in the brains of deceased chronic alcoholics.

Further studies will be announced, Finger said, and the center will communicate closely with other researchers working in the field of aging. For further information, contact K. F. Finger, Ph.D., Associate Vice President for Health Affairs, Box J14, JHMHC, University of Florida, Gainesville, FL 32610.

—Nancy Johnson

Research Centers Conduct Studies on Alcoholism

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has funded two new alcohol research centers and renewed six other centers to continue investigations into the biomedical, behavioral, and epidemiological issues related to alcoholism.

The new grants were awarded to the University of Florida in Gainesville, where researchers will focus on the effects of alcohol on the elderly (as mandated by Congress), and to Hahnemann Medical College in Philadelphia, where researchers will study alcohol's effects on structure and function of the living cell.

The six centers that received renewal grants include the Salk Institute for Biological Studies in San Diego, where the focus is on laboratory and clinical studies of alcohol's effects on the central nervous system; the Mount Sinai School of Medicine of the City University of New York, where the emphasis is on laboratory and clinical studies of the pathological and toxic effects of alcohol; and the University of Colorado in Boulder and Denver, Washington University in St. Louis (MO), and the University of Connecticut in Farmington, where researchers are focusing on alcohol's influence on genetic makeup and genetic influences on the development of alcoholism. The alcohol research group of the Medical Research Institute in Berkeley (CA), formerly affiliated with the University of California at Berkeley, also was re-funded. It conducts studies on the epidemiological factors associated with alcohol abuse and alcoholism.

The centers are selected through the standard grants review process, based on specified criteria regarding such aspects as the proposed areas of research and institutional research capabilities. A panel of research experts evaluates project proposals on the basis of scientific merit and makes recommendations to the Advisory Council. Final recommendations are made by the Council to the Institute.

Additional criteria are applied to centers requesting renewal of their grants, according to Albert Pawlowski, Ph.D., NIAAA's National Research Centers branch chief. "These criteria include the merit of the completed research, whether they recruited new scientists into alcoholism research and provided research training, whether innovative research was implemented, whether the center staff had become an effective research team, and whether the center had increased professional and public awareness of alcohol problems through activities such as publications and workshops," Pawlowski said.

The centers represent a major Federal commitment to developing and expanding knowledge about the causes and consequences of alcohol abuse and alcoholism. They are also an important national resource for training both health professionals and researchers, Pawlowski said.

For further information, contact Albert Pawlowski, Ph.D., National Alcohol Research Centers Branch Chief, NIAAA, Room 14C20, 5600 Fishers Ln., Rockville, MD 20857.

—Nancy Johnson

alcohol digest

Alcohol Digest is a collection of items of interest to the alcohol field. This edition is devoted to items concerning alcohol problems and the elderly, the subject of a special report in this issue.

Materials Available On Elderly Treatment

The Senior Alcohol Services program of Vancouver (WA) has developed materials on clinical treatment issues for care providers working with elderly problem drinkers. These issues include effective ways of approaching clients, physiological and psychological problems, and the recovery process. The materials are based on the treatment programs the group has run in recent years. For further information, contact Senior Alcohol Services, P.O. Box 425, Vancouver, WA 98666.

Program Emphasizes Public Information

The Central Comprehensive Mental Health Center, Inc., of Centralia (IL) has developed a series of three short public information programs to help senior citizens make wise decisions about the use of prescribed medications and alcohol. Issues discussed include how to manage medications, the hazards of mixing alcohol with over-the-counter and prescribed medications, and the effects of alcohol on the body. Presentations have been made at housing centers for the elderly and at local meetings of retired citizens.

For further information, contact Grover Cox, Director, Alcohol Education and Treatment Program, Central Comprehensive Mental Health Center, Inc., 1515 East Second St., Centralia, IL 62801.

Training Manuals Focus on Elderly

The American Personnel and Guidance Association (APGA) has developed a series of manuals to assist in the development and implementation of training programs for counselors and related specialists who work with older Americans. The manuals were produced by the National Project on Counseling Older Persons, a 3-year effort sponsored by the APGA and funded by the Administration on Aging.

The manuals are designed to help plan, develop, and implement communication skills training programs for service providers in the aging network. They are intended for use by counselors, trainers, educators, and administrators — especially those in State agencies, senior citizen programs, nursing homes, and volunteer programs. The manuals vary in cost.

For further information, contact the American Personnel and Guidance Association, Two Skyline Pl., Suite 400, 5203 Leesburg Pike, Falls Church, VA 22041.

meetings

JANUARY

Jan. 19-21. Sacramento, CA. Eighth Annual Alcoholism Symposium. Contact Robert L. Terry, The Community Forum on Chemical Dependency, Inc., P.O. Box 13871, Sacramento, CA 95813.

Jan. 30-Feb. 4. Colorado Springs, CO. Treatment and Rehabilitation of the Alcoholic. Contact Dr. Gary Forrest, Psychotherapy Associates, P.C., 3208 North Academy Blvd., Suite 160, Colorado Springs, CO 80907.

FEBRUARY

Feb. 7-9. Orlando, FL. "Guiding Youth and Adults Into a Drug Free Lifestyle." Contact Milo Sawvel, Jr., Executive Director, National Committee for the Prevention of Alcoholism, 6830 Laurel St. NW., Washington, DC 20012.

Feb. 27-Mar. 1. Chicago, IL. National Conference on Financing Alcoholism and Drug Abuse Treatment Services. Contact Eric Scharf, Alcohol and Drug Problems Association, 1101 15th St. NW., Suite 204, Washington, DC 20005.

MARCH

Mar. 1-3. Chicago, IL. National Conference on Alcohol and Drug Abuse Programming in Colleges and Universities. Contact Eric Scharf, Alcohol and Drug Problems Association, 1101 15th St. NW., Suite 204, Washington, DC 20005.

Mar. 27-Apr. 1. Park City, UT. Second Health and Addictions Seminar. Contact Dan Barmettler, Director, The Institute for Integral Development, P.O. Box 2172, Colorado Springs, CO 80901.

Mar. 28-Apr. 1. Tuscaloosa, AL. Eighth Annual Alabama School of Alcohol and Drug Studies. Contact Peter Balsamo, Division of Continuing Education, University of Alabama, Box 2967, University, AL 35486.

APRIL

Apr. 14-17. Houston, TX. National Alcoholism Forum. Contact Louisa Macpherson, National Council on Alcoholism, 733 Third Ave., New York, NY 10017.

Apr. 26-29. Kansas City, MO. 10th Annual Regional Aging Conference of Mid-America Congress on Aging. Contact Marcia Neu, Administrator, Mid-America Congress of Aging, 701 North 7th St., Room 510, Kansas City, MO 66101.

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